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RURAL HEALTH AID

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON APPROPRIATIONS

UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

SPECIAL HEARINGS

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RURAL HEALTH AID

FRIDAY, JUNE 1, 1990

U.S. Senate,
Subcommittee on Agriculture, Rural
Development, and Related Agencies,
Committee on Appropriations,
Fremont, NE.

The subcommittee met at 3:20 p.m., in Christensen Field, 1730 West 16th Street, Fremont, NE, Hon. J. Robert Kerrey presiding.

Present: Senator Kerrey.

Also present: Senator Daschle.

NONDEPARTMENTAL WITNESSES

OPENING REMARKS OF SENATOR KERREY

Senator **Kerrey**. We're running a little late. We got caught in the wind out there. I appreciate the very good turnout. What I'll do is my opening—can you hear me? In my opening statement I'll indicate what the rules are going to be and how long we're going to be going.

This is an official Senate hearing of the Senate Appropriations Committee's Subcommittee on Agriculture, Rural Development, and Related Agencies. That is the authorizing committee that has scheduled this particular hearing.

I particularly want to welcome Senator Daschle from South Dakota. Senator Daschle sits on the Senate Finance Committee. It's even more unusual to have two Senators who both have a strong interest in health care, and it's fortunate for me as well that those two coincidences are joined by the fact that Tom Daschle and I are also good friends. It's a pleasure for me to have him down for this hearing and one that we will have out in Scottsbluff, as well.

In this hearing, because it's an official one, I'm going to ask that the witnesses that will lead off and then others who have signed up, we will ask you to come up as well, to abide by a 5-minute rule. We have a lighting system here in the front, right here in front of Kate there that will indicate when you have 1 minute left by flashing on a yellow light. There is no light for the stop so I'm probably going to have to cut you off at the end. Don't be alarmed by that. I hope you don't think that I'm being overly rude by doing that. It's just in the interest of trying to give other people the opportunity here to present testimony.

The record will stay open for 1 full week after this hearing so anyone who wants to mail in testimony or provide any written comments after perhaps you have heard something else that's been said, it will be possible for you to get your comments directly into the record either through my offices in Omaha or Lincoln or by mailing directly into Washington, DC.

Very briefly, since as I said, we are behind time, I'll indicate that it seems to me that there is an awful lot of concern at the local level about health care; unfortunately, more than there is today in Washington.

In Washington today we're doing a bit more damage control—perhaps understandably as a consequence of the deficit, but unfortunately. With all the problems that I see in health care today in Nebraska, and the health care problems in Nebraska are shared by those in South Dakota as well, it seems to me that we're going to have to overcome our unwillingness perhaps to approach the subject and approach it much more accurately and aggressively than we have in the past.

The general topic we selected for today's hearing is on rural health care where it seems to me fair to say the crisis is more pronounced than in the more urban environment. That's not only as a consequence of the discriminatory reimbursement system that we have in place in Medicare but it's also as a consequence of demographic considerations and as a consequence of other extraneous circumstances that have made rural health care unique and a much more difficult problem to try to solve.

I am very interested in looking at the way we finance health care all together. I have got enough experience in business to know that practically every single business in the State of Nebraska is facing double-digit increases in health care cost. That means that they are forced to insure fewer and fewer people and those that are still on the insured rolls are apt to get less coverage than they had before.

I have had enough contact with physicians and with hospitals and other providers to know that they are increasingly either harassed or inundated by massive amounts of paperwork. I have had enough contact with individuals who use the system to know that there is increasing amounts of uncertainty about what is and what isn't covered.

We spend more than any other nation on Earth but we, unfortunately, also have more underinsured people than any other industrialized nation. That observation alone should lead those of us who are in positions of political responsibility to try to discover a better way of doing things.

I will reiterate my gratitude for Senator Daschle coming down from South Dakota. He is, as I said, a very good friend, a member of the very important Senate Finance Committee, and very much interested in health care. I will give him an opportunity to make some opening remarks and then we will hear the witnesses.

STATEMENT OF HON. THOMAS A. DASCHLE

Senator DASCHLE. Thank you, Bob. I want to thank you for inviting me to come down. You should know that Senator Kerrey has taken the initiative on this hearing. These two committees probably have more to do with health in the Senate than any others, so we are very appreciative of the opportunity to hold this hearing.

Senator Kerrey has been a tremendous leader and I commend you for sending him to Washington not only to represent Nebraska, but the whole country. He's been particularly effective in talking about health care issues, rural health, and health care financing.

We have a lot of similar problems in South Dakota. If I could categorize the problems, I would list them as being related largely to cost, access, and quality. The problems we find in rural America are similar to those that are found across the country. We will spend about $660 billion on health care this year. That comes out to about $2,400 for every man, woman, and child in the country. That's just unacceptable given the fact that infant mortality in this country is 20th in the world, life expectancy is about 7th or 8th.

We don't have the kind of statistics to justify the tremendous cost that we invest in health care on an annual basis, and so cost is becoming an increasing problem for all the people of our country, especially in rural America. And cost affects the other two categories of problems, access and quality.

In South Dakota in particular, access is affected by the fact that many people can't pay for insurance any more. Sixty-four million Americans at one point during the year have no health insurance at all. Thirty-five million Americans have no health insurance throughout the entire year. And access is limited to a certain extent by insurance. I have had hospitals in South Dakota tell me that they have come to the conclusion that they have to turn away their patients in some cases simply because they don't have insurance any longer. So access is clearly a mounting problem in our State and across the country.

Access is also a problem related to the number of health care providers we have in our State. We have 40 vacancies for doctors in South Dakota right now, 220 vacancies for nurses, and a number of other vacancies for other health providers like nurse practitioners and physicians' assistants. We don't have the providers in part because people aren't willing to come to rural America to practice. We have got to address access from a rural health care point of view.

This administration and the past one have virtually zeroed out all funding for the National Health Service Corps. There was a time 12 years ago when we had 2,400 National Health Service Corps doctors. Now we have it down to a matter of a couple of hundred and it may be completely eliminated in the next couple of years. That's unacceptable.

And finally the question of quality. More and more people are becoming concerned about quality. As a matter of fact, a recent study by Joseph Califano indicated that $155 billion of that $660 billion we spend on health care may be spent on unnecessary procedures. The New England Journal of Medicine said as high as 40 percent of all procedures today may be unnecessary. Forty percent of all caesarean sections may be unnecessary, for example.

We are dealing with quality questions now that didn't exist a few years ago, and those quality issues relate directly to access and cost, so we have got to find some alternatives. We have got to find a way to address all three categories of problems. We have to do it in a way that takes into account the limited options we have and what has succeeded in other parts of the world. So as we begin these hearings, I'm very anxious to hear the comments of the health professionals that we have in front of us.

This is a rare opportunity for Senator Kerrey and I to listen, to learn and, hopefully, to apply what we have learned to some ideas that we all share about ways to improve health care in the future. Thank you, Bob.

Senator **Kerrey**. Thank you, Tom.

First witness is Helen Boosalis, former Director of Aging in the State of Nebraska and now with the American Association of Retired Persons.

AMERICAN ASSOCIATION OF RETIRED PERSONS

STATEMENT OF HELEN BOOSALIS

Mrs. **Boosalis**. Thank you, Senators. I really thank you for the opportunity to speak today. I really appreciate the opportunity and commend you on holding this kind of a hearing which is so necessary to help meet the needs of rural people.

I do represent the American Association of Retired Persons [AARP], and as a volunteer, but the views I'm about to express will be not only AARP's but coincide with my own, and while the focus, I realize, of this hearing is the problems of rural health care delivery system, the real underlying problem with the entire health care system cost can't be overlooked.

In 1988 medical care prices increased by 6.5 percent compared with a 4.1 percent general inflation rate. At the present rate of spending, health care expenditures will more than double over the next decade and will consume more than 15 percent of our Nation's economy. Despite these expenditures, Americans are simply not getting the full value of their health care dollar.

High health care costs lead to access problems, as you both indicated, and access to affordable health care is particularly problematic for rural areas. As a result, many residents of rural communities have less access to a comprehensive health care system.

Congress has recognized the unique problems of the rural health care delivery system but, frankly, to date only modest steps have been taken toward improving rural health care. These include the creation in 1987 of an Office of Rural Health Policy. It includes adjustments in the Medicare prospective payment system to reduce somewhat the difference in payment rates between rural and urban hospitals, and, of course, we thank you for the most recently passed physician payment reform last fall, an additional increase in payment rates for physicians in rural and other health personnel shortage areas.

It is the position of AARP, however, that for all that has been done, additional steps are needed to assure adequate health care in rural areas, specifically trauma care. AARP supports the enactment of legislation to provide States with matching grants for establishing integrated trauma care networks. These networks would link all health care providers so that even small facilities in remote areas would have access to the most sophisticated trauma centers in the State. Legislation creating these centers was approved by the U.S. House of Representatives last fall, last November, but, Senators, this legislation has not yet been approved by the Senate, as you know.

In the area of geriatric training, we believe very strongly that training in geriatrics and rural health care should be a part of the required curriculum for all health care personnel. I remember back when I was director of the Department on Aging, I was astounded to find that of all the doctors graduated from our universities and colleges in this country, fewer than 2 percent had any kind of classes, training at all in geriatric studies.

In the area of social service programs, the Older Americans Act and social service block grant programs are crucial in rural areas. Though substantial support is given by the Federal Government, I think it's important to point out that additional State appropriations are needed to support these services.

States need to evaluate the unmet service needs of older persons, particularly in rural areas, and allocate resources needed to fill those gaps.

In area of rural housing, while probably not directly related to the rural health care delivery system, AARP advocates the supportive housing concept in Federal housing programs. These personal care service programs enable, as you know, older persons who need some assistance but who do not require extensive medical supervision to maintain their health and independence, particularly important in rural areas.

AARP is supportive of special initiative grants targeted to older farmworkers and native Americans, and I think these areas are among the most neglected when it comes to health care. I think it's worthwhile to mention, too, that in the context of reforming the health care system, rural areas themselves need to clarify what it is that they want and need from the health care system so that Congress can identify measures which assure full access to health care, but recognize the differences, in urban and rural areas.

In closing I would like to call your attention to a set of 10 principles that were hammered out earlier this year by the National Legislative Council of AARP of which I am a member. We believe they should serve as a guide to implementing a comprehensive and universal reform, I need to stress the fact that while AARP is the Association of Retired Persons, it is interested in universal health care and strongly supports and will use its resources in every way it can to help Congress develop such a system. Thank you.

Senator KERREY. Thank you, Helen. I'm going to go through all the witnesses and I'm sure both Tom and I will have some questions to ask.

Next witness is Dr. Gregg Wright, a pediatrician and public health professional and also the director of the State Department of Health.

STATE DEPARTMENT OF HEALTH

STATEMENT OF DR. GREGG WRIGHT, DIRECTOR

Dr. WRIGHT. Thank you, Senator. Thank you both for coming to Nebraska for this hearing. I would like to start out by reading a statement from Governor Kay Orr. She would liked to have been here but her schedule would not permit. I am here then and will read my remarks, and Pete Beeson is here representing the Department of Public Institutions, plus we have representatives of social services and all of the health and human services agencies that are interested in this issue.

The statement from Governor Orr reads:

> Thank you for coming to Nebraska and allowing Nebraska families the opportunity to discuss this very important issue. Health care is a concern to all Americans but nowhere is that concern greater than in rural America. In a number of communities here in Nebraska and across the heartland, rural health has become a major focus. We recognize the problems of accessing rural health care and believe that the State and Federal governments have an important role to play to improve health services.
>
> In 1988 the State Health Department created the Office of Rural Health with the responsibility of developing a comprehensive rural health policy and to assist in the development of health care networks among our rural communities.
>
> In addition, through family practice residency programs, the Nursing Incentive Act, and at the Federal level the Rural Hospital Transition Grant Program, additional funding has been made available to encourage health care professionals to set up their practices in rural communities and encourage further development of rural hospital services.
>
> Last fall the first Governors' Conference on Rural Health was held in North Platte and was followed by a series of public forums around the State. Testimony from community leaders and health care providers and families needing care centered on continuing efforts to increase the supply of health care professionals and retain these professionals in rural areas, provide more access and availability of mental health services and to develop new strategies for rural hospitals to survive.
>
> It is important that the Government efforts to improve rural health care provide local community leaders the opportunity to play an integral role in that process. Rural communities across Nebraska are now examining their health care systems to determine and address their own health care needs.
>
> In the past year we have held more than a dozen great town hall meetings in rural communities to determine how to improve the local economy. A part of that focus centers on improving local health care systems. Active communities are now recruiting health care professionals, even giving scholarships to high school graduates interested in obtaining health care degrees with a promise that they will return to provide services in their hometown.
>
> If there is one message that I have heard repeatedly from local leaders, it is that current Federal programs, can create as many problems as they are designed to solve. Some mandated programs while designed to improve health care services, can lead to increased costs that disadvantage rural physicians and hospitals. The same disadvantage is often expressed concerning Medicare reimbursements. Any Federal program must be designed to be flexible to meet the specific needs of rural communities as determined by local leaders. They know what is needed and what will work. Our common goal is to ensure that the rural health care programs meet the needs of families in every Nebraska community and every community in this country.

Now my remarks, and I don't know if my time starts over again or I have already used part of it. I think I'll fit.

Senator KERREY. Thank you, Tom.

Dr. WRIGHT. Thank you. In the past—and I preface it by saying to both Senators that your introductory remarks make it clear that you are already aware of the problems that we are raising, and I hope we can just add some support to that and perhaps increase the focus on the rural health care needs. It does need to be a partnership at the community level which can't be left out, and at the State and Federal level.

In the past few years dramatic changes have occurred in the rural health care system. Many of these changes are directly linked to the changing demographic, social, and economic environment. There is increasing evidence in Nebraska that rural residents have more threats to their physical and mental health and generally must travel greater distances to receive care than their urban counterparts. These problems are compounded by our large rural elderly population and by difficulty in obtaining transportation to medical care. We have experienced an increase in the number of rural poor living in poverty and the rural residents receive a smaller proportion of public assistance than do their urban counterparts. In Nebraska we are concerned about a serious shortage of physicians, nurses, and some allied health personnel such as physical therapists and radiological technicians. Our Office of Rural Health estimates that at least 60 communities are actively trying to recruit a physician. Between 1980 and 1988 the number of physicians in counties with less than 25,000 people, which is over 80 of our counties, fell by 10 physicians whereas the total number of physicians in counties with a population of greater than 25,000 increased by 343 physicians.

While there are many reasons for the shortage of physicians in rural areas, reimbursement is the major one. Medicare payment to physicians in rural Nebraska is up to 37 percent less than to Nebraska physicians in urban areas. We have addressed this problem in the Medicaid program at the State level. In August 1989 our State Medicaid program adopted a uniform statewide fee schedule payment system that provides the same Medicaid payment to a physician in Omaha as a physician in our rural areas.

The primary motive in doing this was to eliminate the inequities in payments that existed between rural and urban areas of our State. Before this change, payment for Medicaid services was based on the Medicare payment system which has a great urban-rural inequity. We urge your consideration in eliminating the Medicare payment differential between urban and rural areas as quickly as possible.

Another serious problem in Nebraska is the lack of obstetric services. A 1989 survey of rural physicians found that 59 physicians or 15 percent of the respondents had either already stopped providing obstetric services or plan to do so within 1 year. Many rural hospitals in Nebraska face serious financial difficulties. In 1988, 32 hospitals lost money and many have resorted to increasing the city or county tax levies to keep their doors open. Since 1986, five rural hospitals in Nebraska, Rushville, Mullen, Burwell, Oxford, and Wakefield have closed and we can expect that additional rural hospitals will close in the next few years. Not all of these hospital closures result in critical access problems in their areas but many will.

Despite these problems, there have been significant positive changes in the rural health care system. These changes are resulted from new State and Federal programs as well as community initiatives.

At the community level, hospitals have diversified their services, formed alliances to share services and joined in multihospital systems. Physicians have established considerably more satellite clinics in small rural communities, scholarship programs and ministering programs are being organized to encourage local youths to pursue health careers. At the State level our medical student loan programs will have placed 32 physicians in rural areas by July 1 of this year. I mentioned the earlier elimination of the urban-rural differential in Medicaid reimbursement at the State level. In 1990 legislation created and provided funding for a State Office of Rural Health and a nursing incentive program. Under the latter program a nurse can receive $1,000 per year bonus for up to 2 years for practicing in a rural shortage area. Also within the past year, four new associate degree nursing programs began operating and one more will be in operation in September of this year.

At the Federal level I would like to acknowledge the hard work and positive impact of the Senate Rural Health Caucus and the House Rural Health Coalition. Legislation that provided funds for the rural hospital transition grant programs provides hospitals with an opportunity to plan for the future and a development of services. Five rural hospitals received grants in 1989. Seventeen applications have been submitted this year. Legislation was also passed to give rural hospitals, compared to urban hospitals, a higher Medicare percentage increase. Unfortunately for Nebraska hospitals, the revised wage index proposed by HCFA will wipe out most of this gain. In 1989 a Federal legisiative package also reduced some of the restrictions on rural health clinics and created a resource-based relative value scale system both of which have a potential for major positive impact in rural care in Nebraska. There are five areas I would like to emphasize where Federal action is important. The first is they need to reauthorize the National Health Service Corps Program. Throughout most of the eighties there were 12 to 15 corps physicians practicing in Nebraska. These physicians reduced major gaps in access to care and some stayed after their obligation was completed, for example, in Franklin, Pawnee City, Imperial, Tecumseh, and St. Edward. With improved matching requirements there will be an even greater chance of retaining both primary care physicians and psychiatrists in rural areas.

Second, the Medicare payment differential between urban and rural hospitals, which has already been mentioned.

Third, we must continue to fund programs that will help communities and hospitals plan for the future such as the Rural Hospital Transition Grant Program. We must also support programs that provide opportunities for hospitals to work together to develop regional plans such as the Essential Access Community Hospital Program and Rural Primary Care Hospital Program, or that develop alternative models for the delivery of care such as the demonstration project in Montana. Programs that provide hospitals with alternatives will help Nebraska hospitals. The solutions for hospitals in the panhandle are likely to be somewhat different than those in central or eastern Nebraska.

Forest health prevention and farm safety are areas that need to be addressed. There is legislation pending in Congress that would help support both efforts at the State level in areas of prevention and farm safety. We are developing a year 2000 goals and objectives report for Nebraska which builds on the Federal year 2000 objectives, but to achieve these goals some additional Federal dollars will be necessary.

In the area of farm safety we may need to address prevention of exposure to farm chemicals, prevention of noise-induced hearing loss and farm equipment safety and occupational rehabilitation to farmers with physical disabilities.

Finally, there is a need to expand the flexibility allowed under the OBRA 1987 Nursing Home Improvement Act to waive the 24-hour-a-day nursing requirements. Because of current nursing shortage, Nebraska nursing homes will have a difficult time recruiting an adequate number of nurses to meet the requirements under the OBRA legislation. Without a more flexible waiver of requirement, some Nebraska nursing homes may be forced to close which would greatly reduce access to nursing home care.

In conclusion, it is obvious that we need to continue to make changes within the rural health care system. We need to provide a framework of supporting resources that will allow different communities and regions to make changes that are best for them.

At the State level we are certainly willing to forge partnerships both with communities and with the Federal Government to make sure that everyone does have access to high quality health care services. Thank you.

Senator KERREY. Thank you, Gregg, and I apologize for making you jam all that into such a short period of time. It was excellent testimony. Next witness is JoEllen Vrbka from the David City Hospital.

DAVID CITY HOSPITAL

STATEMENT OF JOELLEN VRBKA, ADMINISTRATOR

Ms. VRBKA. Thank you, Senators. I'm glad to be here today. I'm administrator of a 34-bed county hospital and I'd first like to share a few of my thoughts regarding the cost of health care, then talk about rural hospitals and what we have done in David City.

I believe that there need to be some incentives in place that encourage healthier lifestyles. It doesn't seem fair to me that nonsmokers, people who exercise and maintain a reasonable weight pay the same health insurance premium as the person who pays very little attention to his or her health. There are too many people without health insurance. I see the problems associated with no insurance and resulting lack of preventive care. I also see unlimited patient expectations. If we get sick, we can be treated almost anywhere regardless of the cost of that care. Medicare now pays for heart transplants, for instance. If we have health insurance, we have pretty much unlimited access to technology.

My dad had a heart attack in the early seventies and his bill was a fraction of what it would be today. However, he had heart damage and lived only 3 years after that. My 43-year-old brother had a heart attack last summer and he received a new drug called TPA which dissolves clots and he needed a balloon angioplasty to open up the arteries around his heart. His bill for that first day was over $10,000. However, when you consider the quality of his life today, that money is well spent, as he had little damage and is productive.

High technology is becoming the standard of care for heart attacks and impacts national statistics leading us to believe the cost of health care is out of control. If we want unlimited access to technology we must be prepared to pay for that care. We may have to decide on some kind of basic health care for all and limit access to the high technology kinds of care to those would benefit the most from that care.

We are also going to have to face the liability crisis. There are an awful lot of tests being ordered in the name of defensive medicine. We need to look at cost benefits of treatment. If I ever have a stroke at the age of 90, please don't put me on a respirator and spend thousands of dollars on me only to let me live in a nursing home for several years. I just cannot believe the answer to controlling health care cost is to reduce payments to providers. We're struggling to provide quality care and provide for the basic health care needs of our community.

Now back to the real world where rural hospitals are now. The advent of payment by diagnosis, as you know, produced drastic change. Rural hospitals in particular have been working at a disadvantage because they received as much as 40 percent less than urban hospitals for similar diagnosis. During the last 2 years Congress has approved larger increases for rural hospitals and we thank you for that. Presently rural hospitals in Nebraska receive 26 to 29 percent less than Lincoln and Omaha hospitals for similar care.

In October rural hospitals will receive a proposed 2 percent decrease. Our update is higher but it's more than wiped out by the decreased wage index. The DRG classification is also being revised up from the high technology down to the most common diagnosis. That results in another nine-tenths of 1 percent additional decrease to rural hospitals. If Gramm-Rudman is also activated, that's another 2 percent, so we could see as much as a 5-percent decrease in payments.

The difference in payment rates for rural and urban physicians also affects hospitals. Doctors remain at the center of health care delivery for obvious reasons. A Nebraska hospital administrator told me last week that he was losing one of two physicians in his community because that physician could make $35,000 more per year in an urban practice doing much the same thing with regular hours. It's critical that the exodus of doctors from rural areas be reversed.

Medicare through the PRO insurance companies and other third-party carriers have been monitoring inpatient care to make sure it's appropriate. This has led to increased outpatient service because some of the care being provided can be done as an outpatient. Even complex procedures are now done as outpatients. Now we hear that outpatient cost of care is too high and must be controlled. Logically it seems to me that we should expect higher costs if there are more people. Cost per visits have to go up if we are doing more complex things. We need to look at the whole system and measure the utilization of personnel and technology before just reducing outpatient reimbursement across the board.

Another problem faced by the rural hospitals is the shortage of health care professionals. For the most part, salaries are becoming competitive with urban hospitals but many rural hospitals can't get nurses, therapists, and other staff at any salary. In Nebraska the associate degree program may help rural hospitals as many of these colleges are within driving distance. I think rural hospitals do provide quality care within the limits of their resources. We try to do the things we can and refer those we can't. We, for instance, don't do total hips but we do fix broken hips and do a good job of it. And Medicare gets a bargain because they pay less to have that hip fixed in our hospital.

In lots of rural hospitals there is increased productively of staff. They have started cross training. Our x-ray technician, for instance, is also our purchasing agent. Many rural hospitals share administrators, respiratory and physical therapists, anesthetists, dietitians, and other professionals.

In David City, we have entered into a joint venture with our physicians to establish a satellite clinic which has helped increase our service area and stabilize the trend toward reduced inpatient care. We will open another clinic this fall. There may need to be more working together by communities to provide the level of health care needed. Perhaps hospitals that are located close together geographically can band together for emergency weekend coverage. Right now I doubt if regulations would allow that and change may be needed. Such an arrangement might help doctors get weekends off and make a rural practice look more attractive. Hospitals need to be ready to offer help to physicians when asked.

Working together, maybe we can solve some of the paperwork crisis. I'd like to thank you for the opportunity to testify on behalf of rural health care and also for your help in our struggle to meet the health care needs of our community.

Senator KERREY. Thank you very much, JoEllen. I know Senator Daschle doesn't know this, but you run a first-rate hospital. Unfortunately, we may not be able to get as much information as Senator Daschle might like to have, but one of the things he ought to know, this particular hospital, though it's small by many standards, is a superb example of what you can do even in the face of all the things that are being done wrong, all the things that you have identified. I would love to be able to change these things, particularly the differential between rural and urban hospitals' and physicians' reimbursement. In spite of all those things, you are doing an awful lot right and the hospital is run well. How many beds do you have?

Ms. VRBKA. We have 34.

Senator KERREY. What's your occupancy rate?

Ms. VRBKA. It's around 40 percent, but nowadays that doesn't really matter because there are so many people, the beds don't get cold and they are not always counted.

Senator KERREY. It certainly is not coincidental that significantly more rural hospitals closed down since the reflective payment system went into effect in 1983. It's not just the wage index and the general lower level of reimbursement in Nebraska. Outside of Lincoln and Omaha, NE, is at the bottom of the list in reimbursement, but it seems to me a failure to take into account the differences that exist between providing care in rural and urban settings. When you talk about a 34-bed hospital, you really open it up into a big area. I'm talking about things, I want to make sure the audience understands, some of you may not understand how that

DRG system went into effect. The DRG system is based upon averages, and when you are dealing with 500 beds or 600 beds or 1,000 beds, those averages mean something, but when you are dealing with 34 beds, the averages don't mean much because you can get three or four procedures that bust the averages in a hurry and bust the hospital in a hurry as well, so I know the kind of difficulties you have had operating that hospital since that system went into effect. I expect it's an example, even if you can get all the rules changed, of what all the rest of us have to do.

The next witness is Peter Beeson with the Nebraska Department of Public Institutions.

NEBRASKA DEPARTMENT OF PUBLIC INSTITUTIONS

STATEMENT OF PETER BEESON

Mr. BEESON. My name is Peter Beeson. I'm testifying on behalf of the Department of Public Institutions. I have got written testimony that I shared with you up there and I can share with my fellow panelists here. The department appreciates this opportunity to speak on behalf of the citizens of the State for whom we provide mental health, substance abuse, mental retardation, and other specialized services. The department also commends Senators Kerrey and Daschle for their attention and support in the area of rural health care. The Department's position is that mental health is an integral and important part of rural health care. In this testimony I intend to make five points. One, there is a strong relationship between physical health and mental health; two, the need for mental health services in rural areas is increasing; three, that the resources available to meet mental health needs in rural areas are decreasing; four, that Nebraska has taken some positive steps in responding to rural mental health needs; and five, there are things that Congress can do to more effectively meet the mental health needs of rural Americans.

First, the interrelationship between health and mental health care. Increasingly research has documented the complex interaction between physical and mental well-being and the current artificial separation between those two service systems is now counterproductive in many areas in responding to rural mental health needs.

I'd like to point out that of all persons who have diagnosable mental disorders, 54 percent receive care exclusively in the primary care sector. Only 21 percent receive care in the specialty mental health sector, and that's more true in rural areas than in general, so it behooves us to ensure that rural health care has the capacity to meet the mental health needs of rural citizens.

Rural health care—rural mental health care faces the same problems confronting the whole of rural health care: shortage of mental health care professionals, poor access to care, lack of emergency services, increasingly poor resource base, and decreasing resources. It is, therefore, critical that when we consider the issues of rural health, we treat mental health as an integral and important part of that effort.

Increasing need for mental health services in rural areas. While there is a lot of recent evidence of the need for mental health services in rural areas, I would like to point out some particular evidence from Nebraska.

The Bureau of Sociological Research at the University of Nebraska coupled with the Department of Public Institutions did a major study looking at the change in mental health status of Nebraskans between 1981 and 1986. As many of you know, the height of farmland values in Nebraska was in 1981, and we had a precipitous decline in the economy after that. Comparing farmers in Nebraska between 1981 and 1986, we found that the rate of depression among farmers rose from 10.7 percent, which happened to be the best in the State in 1981, to 21.4 percent in 1986, which was the worst in the State at that time. During that same period of time, the rate of depression in metropolitan areas dropped by 2 percent. Fortunately, the farm economy has improved somewhat and the recent research data indicates that there has been some improvement among farmers, but that has not brought them up to the level they were previously, and the research is indicating that the mental health of smalltown and nonfarm rural residents is still declining and has gotten worse since 1986.

Decreasing resources. Many States like Nebraska rely on local tax revenue to support rural mental health services or to match State resources to support their services. As the economy has been poor in rural areas, the ability to generate tax revenues for rural mental health services has declined. Also, rural citizens have been less able to provide for their own mental health care because of shortages of their own finances or the dropping of health care insurance.

I'd like to move now to point out a couple of positive responses Nebraska has made to meeting the needs of rural Americans in the area of mental health care. Nebraska was able through some of its efforts in research and other areas to receive a $300,000 rural mental health demonstration grant that allowed us to do a variety of things. I'll mention only one aspect of that grant. We try to explore different alternatives to delivering rural mental health services to populations in the area. One approach was to station a mental health professional in an action center which is a one stop shopping center for farmers who are experiencing transition problems in moving from the farm to another occupation. And we also had a rural mental health professional stationed at a variety of rural physician offices throughout northeast Nebraska. In both cases these services were not only well received by the clients, but also served to enhance the other services at the location where they were. The AG Action Center was able to deliver more effective services because they had mental health services onsite and physicians' offices also reported a positive response in that regard.

Another innovative program for related rural health of Nebraska has been the Nebraska Critical Incident Stress Debriefing Program. One of the difficulties in rural areas in recent years has been the high turnover of fire and emergency services personnel, many of whom are volunteers. Some of the issues related to turnover here are related to the emotional trauma and long-term psychological impact that comes from working in that area. Four State agencies in Nebraska, Nebraska Department of Public Institutions, the Department of Health, the State Patrol and State Fire Marshal's Office have entered into an interagency agreement that developed a statewide critical incident stress debriefing team which is now fully operational across the State and is manned totally by volunteers, volunteer mental health professionals and volunteer peer support personnel that provide preventive and early intervention work with first responders who experience severe emotional trauma as a result of their work.

Finally, what can Congress do? Congress can ensure that any rural health care initiative they initiate specifically addresses the mental health needs of rural citizens and provide adequate resources for meeting those needs.

Two, Congress can promote a better integration of health and mental health services perhaps through grants or other incentives.

Three, Congress can ensure that Federal programs targeted at improving the economy and quality of life in rural America adequately address the health and mental health concerns of rural Americans and include resources to do that.

Finally, Congress can ensure that Federal programs focus their efforts and requirements on outcomes desired rather than on procedures or particular processes to achieve those outcomes. Many of the times rural areas and communities are unable to make use of Federal programs because of restrictions on the way in which they need to do things rather than the outcome desired.

And finally, in general, ensure that funding, regulatory and planning requirements of the Federal Government do not discriminate or place undue burden on rural service providers. Thank you.

Senator KERREY. Thank you. The next witness is Dr. Bob Waldman.

STATEMENT OF DR. ROBERT WALDMAN

Dr. WALDMAN. Senators Daschle and Kerrey, thank you for the invitation. This topic is of great importance to the mission of the University of Nebraska Medical Center. We believe one of the major problems facing Nebraska and the Nation is physician maldistribution. There are simply too many specialists and not enough primary care physicians. There are too many physicians in large cities and too few in rural areas. Many complex factors contribute to the physician maldistribution problem. Some are beyond the control of academic medical centers. Others, however, can be effectively addressed through innovative programs. I feel positive about our ability to influence the maldistribution problems through careful recruiting strategies, coordination and integration of the educational continuum from high school through residency, and good role models in primary care and early experiences in rural practice sites.

One solution to providing more physicians for underserved areas is to identify and recruit promising students from these underserved areas. We know that students recruited from rural areas are twice as likely to return to these areas after finishing their education. Rural disadvantaged and minority students need to be informed that a career as a health care professional is a viable option. There are many myths and misconceptions about what is required to get into medical school. We should take a page from college athletics and do real recruiting of promising seventh, eighth, and ninth graders. The high cost of medical education and the lengthy educational preparation required can also discourage rural students from considering medical school. These barriers can be reduced, thereby attracting capable students who might have ruled out medicine because they thought they could never afford it. Medical education is very long, in part, because of lack of integration in the educational continuum. Traditionally, students prepare for health care careers in separate, disconnected institutions. High schools, colleges, medical schools, and residency programs lack coordination and the result is a disjointed educational experience with waste and duplication of courses as each school strives to give students comprehensive preparation. A coordinated educational continuum can cut 2 years from the traditional medical preparation without any loss of education material, thus saving money and appealing to disadvantaged students.

Another problem with respect to attracting students to a career in rural primary care relates to the research mission of the academic medical center. Because of advances in medical care and technology, medical centers have become increasingly high technology institutions. The high technology, research intensive, specialized care is naturally very seductive with respect to career decisionmaking. Students should spend more time in rural areas early in their education to balance the highly specialized tertiary care they encounter at academic medical centers. They need to know that they can practice exciting, high quality medicine away from research centers.

With a decline in rural applicants to the med centers, we initiated a cooperative with Chadron State College, the Rural Health Opportunities Program. This program recruits students from small, rural communities to become physicians, physicians' assistants, medical technologists, and dentists. Students enrolled at Chadron State College where undergraduate studies are coordinated with UNMC. They are automatically accepted into our program upon satisfactory completion of undergraduate work. Students in the medical doctor program begin studies at the medical center during what would ordinarily be their senior undergraduate year, thus, reducing the total educational time by 1 year. Our first class of 11 students will start at Chadron State this fall. Several of these students would have not considered medicine as a career without this program.

UNMC is currently exploring the possibility of a rural educational site. We feel it would have multiple advantages, providing broad exposure to health problems typically seen in primary care settings, providing interaction between students and rural health care professionals, stimulating early student interest in rural health care and introducing students to health care problems common in underserved and rural areas of the State. We are also exploring the option of a family practice residency program in a rural setting.

Finally, the University of Nebraska College of Medicine along with a few other medical schools, has developed a curriculum which will enable students to start primary care residencies in their senior year of medical school, freeing them from the time-consuming and expensive task of interviewing for residency positions around the country and thereby saving 1 year. It would be naive to suggest that the programs described here will solve the entire maldistribution problem. Other important factors must also be addressed. Medical schools can and should do everything in their power to find creative solutions to this pervasive problem. We hope the changes that we are making will have a positive impact on this country's physician maldistribution problem and will at the same time produce physicians who are better prepared to practice medicine in the 21st century. Thank you.

Senator KERREY. Thank you, Bob. The next witness is Dr. Kate Brown.

CREIGHTON UNIVERSITY CENTER FOR HEALTH POLICY AND ETHICS

STATEMENT OF DR. KATE BROWN, ASSISTANT DIRECTOR

Dr. BROWN. Thank you for this opportunity to discuss the future of rural health. I have given you a chart and it's my testimony and I will pass it either way.

This is not an easy subject, as the saying goes. Prediction is always difficult, especially about the future. I appreciate this challenge to look beyond immediate problems in rural health and to imagine long-term solutions.

I am the assistant director of the Creighton University Center for Health Policy and Ethics. My degree in sociomedical science combines an expertise in sociocultural anthropology and public health policy. My research focuses on the relationship between culture, social structure, and health.

This spring I brought an anthropological perspective to the study of rural health here in the Midwest. I lived in a town of 300 residents, mostly of German Lutheran descent in south-central Nebraska. There I conducted interviews, observed social events and listened to the daily conversations and concerns of townspeople. I was drawn to this town because of its extraordinary success last year in constructing a satellite health clinic where physicians from nearby larger towns now see patients five mornings a week. A combination of $75,000 in donations and a HCFA health care transition grant to a local hospital made the clinic possible.

There are many features of this town that made research there a delight. For one thing, I didn't have to learn a new language and, for another, their cinnamon rolls are the best ever. More seriously, the people of this town were the best teachers that anyone in rural health policy could have. The residents of this town have a sophisticated grasp of the forces and strains that confront their survival as a town and their indigenous health policy reflects this knowledge. I would like to tell you about some important lessons that I have learned from these townspeople and reflect with you on what these lessons might suggest for us as we plan the future of rural health care in America.

A central lesson from this town's experience is that policymakers need to appreciate the complex interplay of economics, demographics, and the availability of health care services when planning for rural health. The townspeople know instinctively that with a clinic they are building for the survival of the town as much as they are providing for community health services. They recognize what this chart in front of you demonstrates, that growth in any of these factors—economy, demography, and health services—can support growth in other factors which can then lead to improved health status. The clinic symbolizes and actualizes a major resistance to the town's principal health threat, depopulation and consequent economic decline. Since the town residents recognize that an individual's health is inextricably linked to the economic health of the town, it only made sense that the clinic address both these needs. Built on the site of a dilapidated building on Main Street, the clinic is a tangible symbol of the town's continuing vitality and health at a time when surrounding towns are dying and abandoned farmhouses are being buried.

The donors to the clinic hope that their contributions would have a ripple effect on the town's economy and demographic profile. An explicit function of the clinic is to keep people in town. As a result of the clinic, elders need not leave for nursing homes so soon and new families may even be attracted to the town. By keeping people in town, the residents can keep money in the town, too.

The clinic has also contributed more directly to the economic well-being of the town. Most of the $75,000 collected in donations for constructing the clinic went to local contractors and suppliers. Through the HCFA health care transitions grant, a local nurse is employed at the clinic. The residents of this town know from their heritage and from their history that every little bit counts in survival.

An important policy lesson from this town's story is that rural health care legislation needs to recognize that health services can be a major catalyst for economic development in rural communities. In rural areas where the economy is dependent on unable markets for their products, there is a need to foster development of community-oriented service and information industries. Legislation that benefits the delivery of health services can have direct impact on the economic health of rural areas. Policymakers need to treat health services as they would any other industry that is willing to locate in rural areas. In order to flourish, providers need tax incentives, low-interest loans, technology assistance, training and relief programs, expedited accreditation, assistance with financial planning. Policymakers need to change the Medicare reimbursement, as we heard a number of times, so that rural providers are not penalized. We need to learn from the experience of Canada. Recognizing the linkage of community health to community economic health, Canada actually compensates rural health providers at a higher rate than their urban counterparts through their national health program.

Furthermore, legislators must recognize that just as assistance to health providers has a ripple effect that benefits both health status and rural economy, so, too, do economic programs affect the overall health of rural residents. Epidemiologists tell us that illness rates are more highly correlated with economic and social environments of individuals and populations than with the availability of health services.

People in poverty experience more of their share of excess disease and death in the United States even when affordable health services are available. Logically then, it makes sense that legislation to affect rural health status must be concerned with broad public health and economic policies that impact on the social and economic concerns of rural people.

The health of rural people and the continuation of rural services depends on continued support for such initiatives as the Rural Partnership Act of 1989 that provided funding for rural economic development and the upkeep of basic public health infrastructures in rural areas. Legislators need to support initiatives such as limitations on farm size that preserve population base in rural areas, and we all need to pressure our GATT negotiators so that they do not limit congressional powers to initiate farm programs.

These initiatives may seem somewhat removed from the usual concerns of those interested in rural health but my mentors in south-central Nebraska taught me well that the future of rural health depends on the future of rural life. That future is ours to shape. Thank you.

Senator KERREY. The next witness is the immediate past president of the Nebraska Medical Association, Dr. Richard Raymond.

NEBRASKA MEDICAL ASSOCIATION

STATEMENT OF DR. RICHARD RAYMOND, FORMER PRESIDENT

Dr. RAYMOND. Thank you, Senator. My name is Dick Raymond. Not only am I immediate past president of the Nebraska Medical Association and speaking here on their behalf, but I have also been in family practice in O'Neill, NE, for 17 years. I may be able to connect with Senator Daschle more than the other speakers as I'm just 40 miles from the border. I spend a lot of weekends at Francis Case Lake.

Several of the speakers have already touched on some of the subjects I wanted to bring up, including, as Kate mentioned, the Canadian experience of paying rural physicians more. Dr. Wright mentioned the number of towns looking for physicians. I would like to point out just a little bit, though, to give you a sense of urgency to the problem, not only have 19 counties lost physicians in the last 3 years and 19 counties currently have no physicians, but 24 doctors have left rural Nebraska in the last 10 months. O'Neill, the community I have practiced in for 17 years, 1 year ago had five physicians. As of today, they have one. We set up two satellite clinics, Kate, many years ago, perhaps one of the first ones in Nebraska. And they are both now closed because there is no one to staff them.

Dr. Waldman and the dean from Creighton University did a study for the medical association, or with us, 1 or 2 years ago to try to determine why the applicant pool is declining, and they found 67 percent of freshmen and sophomore medical students were advised by their family physician not to go into medicine. That's the amount of disgruntlement that is out there with current policy.

Physicians are no longer staying in rural Nebraska or going to rural Nebraska because of many factors. A lot of it is just the bureaucracy and regulations of the MAAC's, PRO's HCFA, liability. Another major reason is the disproportionately high percentage of Medicare and Medicaid patients that we have in rural areas. With that large elderly population there are a great many Medicare rules. They affect us perhaps two times more than urban physicians. Many of our residents of rural Nebraska are self-employed, particularly farmers and ranchers, and have no insurance so payment is more difficult for them.

When a student graduates from medical school with a $100,000 indebtedness, he looks at how he or she is going to pay it off. They look to the other specialties that may reimburse them at higher than family practice. If they do go into family practice, they look at where they can make the most money to service that debt, and that is in the urban areas, as has been mentioned many times today because of the disparity which I would like to talk about a little later.

Currently for those in the audience who do not know, there are 237 geographical payment areas in the United States. That's 237 areas that have different payment schedules for the same procedure, and of those 237 payment areas, rural Nebraska is No. 236, next from the bottom. I don't know how anybody practices in rural Nebraska. Medicare is the only insurance company that I know of that has a uniform premium throughout the United States. Every Medicare patient pays the same premium regardless of where they live but the reimbursement is based on where they live, not on their needs or on their wealth. In Nebraska 32 rural physicians participate in Medicare. Therefore, our patients have to pay more out of pocket to see the physician because the Medicare reimbursement to the patient is the second lowest in the Nation. Therefore, our senior citizens are being tapped twice. It is socialized medicine. They are supporting health care in Miami and Los Angeles and New York City and it's just not fair. The only explanation I have for it is there are more votes in those populated areas.

There are 237 categories, we are told through the Medical Association and HCFA based on 1973 charge data that is not available for Nebraska. We have tried for years to get ahold of that charge data and it cannot be found. In 1973 I did not practice medicine but I was still punished by the fee schedule of 1973, and at that time health care was cheaper in rural areas and health care was less adequate in rural areas also. Rural physicians now at rural hospitals are expected to deliver the same quality care as they get in the cities. Delivering that quality of care costs a lot more money than it used to but we cannot raise our fees to compensate for that. Our costs include higher skilled personnel such as nurses, laboratory technicians, and x-ray technicians. It quite often takes more money to hire them in rural Nebraska than it would if you live in an urban area. We have no group purchasing of supplies with a one- or two-man clinic. The equipment will be underutilized. We have one or two doctors using one x-ray machine and it doesn't get used as much as if you have a 10-doctor group using that x-ray machine and it takes longer to pay it off.

Insurance is often higher for physicians in rural Nebraska because in rural Nebraska we do obstetrics. If I lived in the city, I might not do obstetrics, I could lower my malpractice premium. I have no choice in a small town.

Office space is not cheaper in rural Nebraska. In fact, in rural Nebraska you either rent from the only person that owns the clinic or you take out a mortgage and build your own clinic. You do not have a choice of where you practice. Continuing education costs more money because you have to take a day off to come and testify at meetings like this. You don't get continuing education, you cannot drop across town for a 2-hour course and gas costs more. The Texas Medical Association has done an indepth study of cost differences between rural and urban practices and they reported to PPRC, physician payment review committee, about that and found that rural costs are 15 to 30 percent higher for rural practice of medicine than urban.

The American Medical Association also did studies that coincided well with Texas Medical Association studies that showed rural physicians having more patient contact with older, sicker patients, working longer hours with less cross coverage. They also found that in rural areas for the average family physician, 60 percent of his patients are Medicare, compared to 30 percent in urban areas.

The Physician Payment Reform had promised to solve this problem. However, section 4001 of H.R. 3299 states that, "Beginning in 1992, the relative value for each physician's service is based on the sum of three components, general practice expenses, malpractice expenses, and physician work." The general practice expense component is defined the same way as the practice expense component was defined for earlier years, except that malpractice expenses are now excluded.

It goes on to define that each urban and each rural area within each State as those areas are defined for payment purposes now will be used in prospective payment system.

We have tried to contact the PPRC to testify and we have not obtained any satisfaction with them. Currently PPRC is investigating the GPCI, geographical practice cost index factor. This uses 1980 census data for labor, input prices and assumes one national price on supplies and equipment.

They have three current options the PPRC is considering recommending to Congress in July. One would maintain the current 237 areas as they are. One would go statewide which would be a help but they say they cannot do that because of States like California, the large metropolitan areas of Los Angeles versus the rural areas. So the one they will probably recommend will actually add areas. Call it the metropolitan statistical areas/rural. There will now be 365 geographical payment areas. Nebraska, if you go statewide, will be paid at a ratio of 0.90 which would be second lowest in the country. Senator Daschle, South Dakota, incidently, would be 0.91. They would be a step above us now. If they go MSA/rural, which is most likely, and that uses the current hospital PPS system, Omaha will receive payment of 0.93, Lincoln will receive 0.91 and all the remainder of Nebraska will receive 0.88.

Rural South Dakota will receive 0.89, there will be a 5-percent differential between rural Nebraska and Omaha, and, back to my main point, as long as there is a 5-percent differential, why won't that young doctor stay in Omaha where he does not have to take as many emergency calls at night, has more contact with other professionals, can get continuing education easier, and has a better social life. For a 5-percent difference, he will stay in Omaha. He will not come out to the rural areas. We need help in getting rid of that disparity in Medicare reimbursement because it affects us in rural areas even more than it affects the doctors in the city because we see a larger percentage of Medicare patients. The Nebraska Medical Association's house of delegates has had a unanimous vote twice in favor of a one-tier payment system for Nebraska. Omaha and Lincoln doctors do realize what's fair and what they need to do for rural Nebraska. We need your help. Thank you for allowing me to testify.

Senator KERREY. Thank you. Your last point—that the house of delegates voted unanimously, meaning that Lincoln and Omaha doctors are willing to change the reimbursement schedule principally because, as you say, it's unfair—is significant. There is an awful lot of people that say, "That may be unfair but if I have to give up something in order to get fairness, I may not be willing to do it." the house of delegates vote is a very strong example, I think, of how unfair the current system is. We will try and set up through Senator Exon's office, a meeting with the Nebraska Medical Association at HCFA.

Dr. RAYMOND. We have traveled to Washington, DC, and have met with representatives of the Finance Committee, the HCFA, your office, and Senator Exon's office. That's why I ran for this job 2 years ago, to try to maintain access to rural health care, try and solve this one problem.

Senator KERREY. Did you make any progress?

Dr. RAYMOND. I got into Senator Exon's office and I met your health aide.

Senator KERREY. Thank you.

Dr. RAYMOND. We did make progress, as Dr. Wright already pointed out. We did get the State and ourselves to work together to go to a one-tier system for Medicaid.

Senator KERREY. The next witness is Dr. Leslie Schlake, family practitioner from Broken Bow.

STATEMENT OF DR. LESLIE SCHLAKE

Dr. SCHLAKE. Senators, first of all, I would like to express appreciation for being invited here. I have been sending letters to Washington for a long time and I didn't know if anybody was listening. I'm glad there is somebody there.

You have heard over and over again, I'm sure, from many of the practicing rural physicians their interpretation of the cause of hard times in rural medicine. I would just like to point out I'm not here to complain about my income. My partner and I have generous incomes. I do, however, wish to point out that my partner and I work 80 hours a week in order to generate that income and make a living. I don't want rural health care issues to be minimized as simply a bunch of whining physicians wanting more money. What we're really demanding is a little bit of respect, a little less paperwork and an improvement in our lifestyles. Dr. Raymond already brought up how many physicians have already left the area. I don't think there is much prospect of them coming back and being replaced in the near future. There has to be a reason for this. Some of it is certainly monetary, and, I think, the Congress owes it to rural physicians to at least pay them an adequate wage. They need to realize that in giving us an adequate wage, it doesn't mean we are going to get rich.

What I would like to do is have reimbursement levels that are fair and competitive so that I can attract another physician to my community and in so doing I can cut my 80 hours a week down to 60 hours a week. With 60 hours a week I can participate in the rest of the life of the community.

Right now I'm not involved in anything, not Rotary, not sports, not school events not even the upbringing of my children. I think that is the heart of the rural health care dilemma. We don't have a life there. Physicians are placed at an economic disadvantage. They make up for that by spending more hours working. Soon they are burned out, disgruntled and they opt for the city where they make a good living and have a personal life. The result is that rural areas go shortchanged.

Another dilemma facing rural physicians is the excessive paperwork brought on by HCFA and PRO's. And I agree that they have to have some cost containment and have to do that on skilled physicians. However, the current system is inadequate to do either. It generates paperwork whether you are a good physician or a bad physician. They just keep firing papers at you and they don't know what's going on.

So far the PRO's have identified two practicing physicians in the State of Nebraska and singled them out for discipline. That's out of 2,400 physicians. They have harassed every single one of those physicians in the process. They expended millions of dollars in the review process and generate very little benefit for what they have done. Money could be spent better elsewhere. These agencies cannot really tell from their process whether you are doing good or bad, whether you are practicing economically or not. Persistence seems to be total arbitrary, haphazard and I don't think there is any method in the madness.

Unfortunately, these institutions were designed as cost saving but they have not realized any success there either. Rather than concentrating just on physician reimbursement, I think we need to concentrate on broader issues: the survivability of our health care system in general. Right now it is threatening to either consume the entire national product or destruct itself due to lack of finances. It's at a crossroads. We need to get an organized system nationwide which can be fair and equitable not only to rural physicians but to urban physicians. We need to talk about a one-tier system in this country with universal health care.

The working class taxpayer is footing the bill right now, either he's paying his taxes and the government is dispensing it or he's paying his insurance premiums and the insurance companies are dispensing it. In any case, he spends 40 cents of his dollar administering the cost and only 60 cents on medical care. We need to rectify that. If we could utilize the administrative money in the actual care of people, there would be plenty for all. The Government needs to recognize that there are limitations to what the medical system can give to anybody. We are not capable of giving everything to every person. No matter how much we expend on any individual, that individual will eventually die. It's a God given fact that we are born into this world and we are going to die. We need to set realistic goals as to what an individual can expect from health care and then have a one-tier system which is capable of enforcing those limitations.

Right now no such limitations exist. With a haphazard approach to financing medical care, no one can say enough to anyone. In the current system, the physician is in charge of saying no. When the Gramm-Rudman hits and there is a decrease in the budget by 10 percent, I do not have the ability to say no to 10 percent of the heart attack victims. I will not be able to say no to a fracture victim and I will not be able to say no to a delivery. I simply have to take care of them.

In closing, bookkeeping techniques in the real world of medicine are impractical, yet that is the system we have. It is grossly unfair and right now is hitting the rural sector harder than it is elsewhere. Our system is becoming bankrupt. We have only HCFA and PRO which cannot address these problems. They have placed the physician against the patient, the patient against the hospital and generated ill feeling. There isn't a day that goes by that I do not admit a patient to the hospital that expresses fear of being rejected by Medicare. There is a definite fear in this country of losing all health care. In the rural areas I think this fear is justified, much more so than in the urban areas. It is the current system and regulations that bring this fear. You as the leaders of this country need to address that fear. Medical care is a necessity in life and is a commodity which most people feel is a right. You need to do what you can to guarantee that right not only for urban centers but for rural areas and for everyone, rich or poor. We need to set realistic limitations as to what people can expect. Not everybody should receive 200,000 dollars' worth of medical care. We need to build a system which this country can afford, setting standards at a level that most people can accept as legitimate. You must build disincentives into the system that not only the physician has to enforce but also the patients themselves. A copayment system would be a good disincentive. And you really need to consider it in the next Congress. In the meantime, if the reimbursements levels could be made a little more fair, that would certainly help the bird of crisis in the rural areas. With the flight of physicians in these areas there will soon be no hospitals, no physicians, no clinics nor other facilities to worry about, except in 5 years we can come back and establish them at three times the cost.

I'm charging you with the duty to go out and devise a survivable system which guarantees adequate levels of service to everybody, to guarantee reimbursements to physicians and hospitals, to guarantee their survival and to do it quickly. If you do that, I'll quit complaining and you won't hear from me again.

If you do not, you will be hearing from me as well as from patients; anyone I can bend an ear on. I believe there is a general fear in the rural population of losing health care and they will not be silenced. When the health care goes out of rural America, so does the business and industry, so do the schools. You will see a collapse in rural culture. You have a great responsibility before you. Good luck in seeking a compromise with your colleagues on these problems but you must seek it quickly.

Senator KERREY. Well, we are at the end of the hearing—oh, I'm sorry, one person left, Jim Dietloff, Goldenrod Hills Community Action Council, Wisner, NE.

GOLDENROD HILLS COMMUNITY ACTION COUNCIL

STATEMENT OF JIM DIETLOFF

Mr. DIETLOFF. Thank you, Senators. I kind of tossed you a curve, too, in asking to be shifted to the end, but I was kind of penciled in as a replacement, as I understand it.

I don't have written testimony and I asked to be placed at the end to have an opportunity to hear what the others had to discuss and maybe fill some voids as I saw them, and I do want to today represent the patient viewpoint and the recipients as we see them day to day in our operations with Goldenrod Hills.

For those in the audience, I might tell them that the community action agency or council is involved with a number of the social programs that are administered in the State and across the Nation. Some of those you may be familiar with are Head Start, the WIC program—women, infants and children—commodities programs as it pertains to nutrition for seniors and also for the maternal child health care programs and then also the health component of Head Start.

As we work with the people in the field, we're working basically with those who are considered those in poverty or those who are what I call the working poor.

We have large numbers of those people in rural areas, partially due to the farm crisis and partially due to other things that have happened in our rural setting.

When we speak of the working poor, we are also looking at people who may be insured but because of changes that have taken place in the health care field, we're seeing many companies change from the $100 deductible to the $250 deductible and in many cases to the $500 deductible. To those individuals who are on a meager paycheck, it's just as difficult for them to pay the deductible as it is to be confronted with the billing in the first place.

As a result, we don't see the preventive health care that should be taking place in the rural communities. I'm speaking of the examination that should be done once a year for each individual. It just doesn't happen. They don't spend the money to go, and as a result, most of the conversation here today ends up being regarding acute care and what is it that we can do to provide a service there at a lower cost.

Some of the lower cost can be achieved by addressing some of the preventive health care programs, and I think that the WIC program has been strengthened each year by Congress. It needs to be continued as a component that can help us greatly. Parts of Nebraska have the full maternal child health care program, and I'm glad to see Dr. Wright testifying here today because that also is another program that hopefully can be funded to the fullest in the State of Nebraska and provide additional support.

We have immunization clinics that we also conduct and in those immunization clinics we see a lot of people. The measles epidemic that was occurring in some parts of the Nation spawned a lot more activity. We discovered that a lot of people out there hadn't had the shots that they should have had but all of the sudden that little crisis brought them forward and our clinics were somewhat overwhelmed with numbers because of that.

Transportation to these services also is something that we need to consider. We don't have the kind of transportation to the metro areas that we should have, and the possibility of developing service then that goes to the communities, I think, is very important.

The nurse practitioner program should be enhanced in some way. A tie-in with the training component at the colleges which would take these internships to the field and do those things in a clinical setting to me spells a lot of sense, and it might save an awful lot of money, too, as far as the delivery of that health care at that end.

I talked to a hospital administrator this morning regarding the reimbursement factors that they are facing and I think it's very true that rural Nebraska hospitals will lose from $18 to $20 million because of some of the wage indexing that is taking place and those things.

However, their group is planning to do some work this summer, it's called an issue in strategy group. The goal is to assure access to care whether it be preventive or whether it be in the acute area. My hats off to them for that and I hope that we can provide some assistance in that area. I would hope that those people, hospital people will look to agencies such as ours for some input as to what we're seeing in the poverty area out there in the field. Don't forget the preventive side, I guess, is my encouragement to you, and I hope that we can work further with you in that regard. Thank you so much for the opportunity to present. I would like to spend more time with you on that subject.

Senator **Kerrey**. Thank you. Just so everybody understands, we have passed the 4:30 mark which is when we were going to close the hearing, but because we were here a bit late and because there is a lot more testimony that I would like to get and because I would like to ask some additional questions, we're going to continue to run for another one-half hour, 45 minutes, so those of you that signed up for the open mike, we will still give you that opportunity.

Dick, if you don't mind, I would like to ask you a question, Dr. Schlake's testimony obviously brought a response from the audience. It did from me as well. I'm going to ask you to respond in particular to what appeared to be a call to nationalize an essential level of service that you can provide. I saw you flinch when I used the word "nationalization," but it does seem to me that we end up with a very fractionalized system if we get in and try to simply fix it at the edges, as we have done in the past. We're apt in the end to make the darn thing worse. Increasingly I'm hearing from people who like the Canadian system. I saw you nod and approve when Kate was saying that the Canadian system has a method where they can actually reimburse at a higher level for rural care. As you accurately said, the reason we don't do it in the United States is votes. I was not around either when they put the DRG's into place, but I'm quite certain that votes dictated why they did it that way and certainly votes dictate why it is difficult for us even to narrow it down to 7 percent. But I'm interested, first of all, in your personal opinion about what you think we ought to do.

Dr. **Raymond**. Personal opinion?

Senator **Kerrey**. Yes.

Dr. **Raymond**. Well, my personal opinion, not speaking for the Nebraska Medical Association at this time is that Medicare is socialized medicine, national health care for the elderly and Medicaid is for the indigent. And I think the Medicare system is so broken down that if we did that to everybody in the United States, we would have a wholly broken down health care system. I'm not sure what the answer is. But I think the example of the bureaucracy and the waste of money that goes on with the Medicare system, as Dr. Schlake mentioned with the PRO and the money that was spent on that organization to find the two physicians who were bad—in Nebraska, 5 or 6 years, that is a lot of money that could have been spent for health care. I think if we had a national health care system, we would end up having that type of bureaucracy affecting everyone from birth to death and I'm scared to death of that kind of stuff myself.

As Kate mentioned, up in Canada, I know they pay an incentive. If you go to rural areas in Canada you will be paid a bonus of, say, 20 percent. And if you go to a medium-sized area you are paid the national fee. If you go to Montreal you are paid 80 percent of the national fee. That's an incentive to get physicians to rural areas. That part in the Canadian health care system I like but I don't like the rest of the health care system in Canada where there are not the tools to provide good quality health care that we have in the United States.

Senator **Daschle**. I'd just be interested, what is it about Medicare that you think is broken down? The reason I ask the question is because we have 1,500 insurance companies in the company right now, and the average administrative cost in our system is about 25 percent. We talk about how technological our system is. Well, it's also a very bureaucratic system. Twenty-five percent of our health care dollar gets eaten up in bureaucracy.

Now, the anomaly is that in the Medicare program, only 4 to 5 percent of expenditures are for bureaucracy, and 95 percent are for health care. This is substantially better than in the private health care system. Given that, what part of Medicare do you feel is broken down?

Dr. **Raymond**. Well, I think, one, it is wrong that they take everybody over 65 and charge them $500 premium for health care insurance. I think there are many elderly who are wealthy elderly who go south for the winter could pay their own health care premiums and get some of that monkey off of the young taxpayers' back. It's the person that has two kids and is trying to pay for a house, pay for a car, maybe even save money for college for his kids, but he's subsidizing the health care of the people down in Arizona and Galveston golfing for the winter. I think the part is wrong. I think the PRO is wrong. I think the money wasted there and the hassle to the average practicing physician, I mean almost daily letters accusing you of this and accusing you of that. I'll give you one example, just a couple months ago, got up at 2 in the morning to see a patient, a Medicare patient with severe abdominal pain 2 months post operative of abdominal surgery done elsewhere. I spent 1½ hours with that gentleman that night, from 2 in the morning to 3:30 in the morning and finally transferred him to a larger city back to his surgeon to have exploratory abdominal operation done. I had a laboratory technician come in, I had an x-ray technician come in, of course, and had a nurse there on duty. When I got a letter from Medicare 3 months later stating that I had to pay that patient $20 back because I overcharged him and I could only charge him $12.80 for that 1½ hours' work in the middle of the night—I found out the x-ray technician got $18, the laboratory technician got $20 but my fee is $12.80—I threw up my hands there and I said, "I quit." As of last Wednesday I'm no longer practicing in O'Neill. I can't take that type of harassment on a daily basis. The threats make me sound like a criminal. Of course, a copy of that letter went to the patient saying the doctor overcharged you, he has to refund you this $20, and if you go to a participating physician next time you won't have to pay anything. That type of bureaucracy has gotten to me.

Senator **Kerrey**. That's not an unusual anecdote. I have heard more than just that one.

Dr. **Raymond**. Well, there are hundreds of them.

Dr. **Schlake**. I didn't say national, I said, one-tier. You need to have one boss whether it's the national Government or the insurance companies because right now there is nobody to set the limitation on expenditures. If you are saying cut costs but guarantee every service in the book, well, if there are 15,000 insurance companies, they can take all your medical care to different levels and we have no input, we have no way of setting them out.

Senator **Daschle**. You are saying then a single payer?

Dr. **Schlake**. I don't care who has it.

Senator **Daschle**. OK. You don't care who has it as long as it's a single-payer system?

Dr. **Schlake**. Uniform system.

Dr. **Raymond**. I prepared a physician paper at the end of May 12 months ago that I would be glad to send you, Senator, that what the AMA has passed and approved that's possible. It's one idea.

Senator **Kerrey**. I appreciate that. What is given, it seems to me, in health care is that most of us aren't concerned about it until we need it, and most of us are healthy. You know, I have had a couple of unusual incidents in my life that caused me to extract a bit more from health care than most, but the minute I get healthy again, I forget about it. In addition to that, it's extremely complicated, not just the technology of it but the ins and outs of all the different acronyms and everything that you have to try to figure out if you are in the business that I'm in and try to figure out how the whole system works.

In addition to that, it is human nature to try to control whatever you have got the responsibility to control and forget about everything else. So if I'm a State politician, I worry about controlling the cost of Medicaid. If I have got rapidly increasing Medicaid costs as we had in the early 1980's then, I put in place controls to try to check the escalating Medicaid costs. It doesn't make any sense if you are out delivering health care.

The same rationale applies to Medicare. If you have got every single politician in the United States of America out campaigning against a tax increase, that's bound to increase the pressure to keep that budget under control. That means things are going to be done that are in conflict with what we have been talking about here, in relation to health care. It doesn't seem to make an awful lot of sense to me.

You made an excellent preliminary list, it keeps lengthening, of ways to control costs in health care. It would make a lot more sense to simply decrease the reimbursement to providers. Again, though, you do control whatever is in front of you. That problem relates back to what Dr. Schlake has said. Unless you bring it all inside the same system, somehow, you end up squeezing at one end and all of it just pops up out in another area. And, you know, you can blame the politicians and you can blame whoever you want to, but it seems to me that somehow we have got to start bringing everybody in inside of the same thing. Otherwise, all we're going to do is fix one part and it will be lousy in another area. We're going to just keep generating more and more paperwork, and the letters that harass you are going to go to somebody else but they are going to still be out there and in increasing frequency.

Dr. Wright, I'm going to ask you some questions. It might be just as well to make a list of and get back to them later. I would be interested to know in relation to 2056, the Health Objectives Act that you mentioned, what sort of things the State would do if we are able to get that act passed. I know that you have an awful lot of interest in preventive care and public health and particularly as it relates to rural areas, and you touched on it toward the tail end. The second issue I would like your input on is the legislation to either require or provide the resources for the States to develop their own health plan. It would be a comprehensive health plan including rural care and all three elements: the private pay, the individual pay, the third-party insurance company and Government pay, whether it's Medicaid, Medicare, or through Veterans or through armed services. Third, I would like any comments you might have on what Oregon has done. I am not just referring to the rationing of Medicaid and the overall list that they put together, but also the mandate I understand they have enacted and the high-risk pool which we already have in place to try to make them a bit more reasonable. Fourth, I would be very curious to know whether or not you think what the medical system facility in Montana has a request in for would be something that would work in Nebraska as well.

Dr. WRIGHT. OK.

Senator DASCHLE. Bob, I would like to pursue this idea of the single-payer concept a little bit more, because as I look at our options, frankly, I'm not very wild about mandating health insurance for everybody out there in the private sector. I'm not sure that solves anything. I think there are too many gaping holes if we try to mandate it and then make up in Medicaid what we can't cover in the private health care field.

That doesn't enthuse me. The American College of Physicians and, I understand, the National Association of Social Workers have come to the conclusion that Dr. Schlake is right, that in order for us to deal with access and cost and maybe even quality but certainly bureaucracy and a number of other things, we have got to start looking at a single-payer concept in this country. Would anybody object to that concept as a solution? Is there any objection in this group to that idea?

Dr. **Raymond**. I would just like freedom of choice. I would like to pick out my insurance carrier.

Senator **Kerrey**. Your insurance carrier or your physician?

Dr. **Raymond**. Both, my insurance company and my physician. I would like the freedom of choice.

Senator **Daschle**. Second question, short of a single payer, wouldn't it make more sense to put all health care providers under Medicare? I'm talking about nurse practitioners, physicians' assistants, et cetera, in rural areas. If we are really talking about health provider shortages in this country, it just seems to me common sense that we want to get as much help from as many different kinds of providers as we can. Is there any objection to that?

Dr. **Raymond**. My yellow light came on when I was talking. We can't hire PA's out there because they can make more money in Omaha or Lincoln. Their doctors are paid more in Omaha or Lincoln so they can reimburse them more and it's hard to get them out there. I have had a PA working for me for 13 years. Fortunately she's married to a local farmer but she can stay in Omaha and make a lot more money because they are paid more. She sees a Medicare patient. Medicare pays her less than they would pay me. I mean, the reimbursement goes down for PA's. Yes; I think there is a place for PA's. I have used one for many, many years as an aide, as an extender. They don't take calls. They don't deliver babies. They don't operate, though. There are things they don't and can't do and they shouldn't do.

Senator **Daschle**. But there is a whole lot they do do.

Dr. **Waldman**. I would be concerned about how broadly you define health care providers because there are people who call themselves health care providers who are untrained, unqualified. Without stepping on my toes, for example, naturopath, if they are going to be included in that, then I would object.

Senator **Daschle**. I'm talking about some of the more traditional health care providers, nurse practitioners, physicians' assistants, people like that. I know we have a lot of people that want to be heard so I'll limit my questions to that.

Senator **Kerrey**. Thank you all very much. Just six out of here and the first six that signed up, and we'll see how long that takes. Marianne Nielson, Kathy Boellstorff, Kathy Chatt, Connie Wellman, Karol Osterloh, and Senator Stan Shellpepper.

STATEMENT OF MARIANNE NIELSON

Mrs. **Nielson**. Thank you, Senators, for giving an ear to health problems, and I would like to say yes and amen to those who preceded us, especially the last three. I probably shouldn't tell you that I'm the one who wrote you on health problems, about the trees, the red birds and thought maybe you ought to sell Washington, DC, to the Japanese.

I would like to address the apparent lack of concern for the patient under present health care in the United States because of

Medicare. Through personal experience and firsthand observations, I see that treating rules and regulations has become more important than the patients' treatments. If per chance the doctor would put the patient first and admit them for care not defined in the rule books, which I have witnessed as being very thick, the doctor could be sanctioned with the hospital who, of course, would not be reimbursed for services.

Now, of course, not all regulatory laws are bad, but in my opinion and many others I have visited with, the Medicare pendulum has swung too far. In the meantime, the patient suffers. I have time to cite only one example and it will seem small among those I'm sure you have heard. Because Medicare about 4 years ago declared pain even of unknown cause and no matter how severe to be not worthy of even overnight observation and treatment, one is turned away. And this is when a doctor has sent you to the emergency room. This was the experience that we had last January 6. This can be more devastating than the ailment. Having insurance does not open the door, for other insurance companies are following the Medicare strategy. I still believe that the doctor knows more about one's needs than the insurance company. As retirees in our sixties and carrying insurance all of our life, we had hoped to rest very secure in health services. Not so. In January of this year we were notified by Mutual of Omaha and Omaha Public Power that if we did not use preferred doctors and hospitals, we would pay an extra 10 percent more than others and we would receive double deductibles where they apply. They would be doubled. To comply, we would need to drive twice as far to a hospital in much more traffic and change doctors. It appears that the big ones are calling the shots and will soon gobble up the little ones. I urge you to help that pendulum swing to the center where perhaps the patient may be considered. Peace of mind would be good preventive medicine which, by the way, insurance companies have not yet adopted.

We are grateful for the health coverage we have and we pray that it will be there when needed. There are many fine hospitals in Nebraska, many fine small hospitals and we trust you to make them more accessible and affordable. Thank you.

Senator KERREY. Thank you.

Mrs. NIELSON. Thank you.

Ms. BOELLSTORFF. Senator Kerrey and Senator Daschle, I did submit some written testimony but I would like to just visit with you. I am a producer from——

Senator KERREY. Could I get you to state your name?

WOMEN INVOLVED IN FARM ECONOMICS [WIFE]

STATEMENT OF KATHY BOELLSTORFF

Ms. BOELLSTORFF. Kathy Boellstorff.

I am a producer, a farmer from southeast Nebraska. I also work at the Nemaha County in Auburn. Today I'm representing WIFE, women involved in farm economics. I have two concerns and you have talked about them innumerable times: availability and affordability today. I'd like to give some examples and at the end maybe some solutions that I think might be affordable.

A neighbor had an accident about 1 year ago. He was working out in the pasture grinding feed in a grinder mixer and got his arm caught in the gearbox. He had taken off the shield to work on parts because it had been broken down and the parts came that day and he hadn't got around to fixing it yet. Anyway, his arm got caught in the gearbox and up to his armpit was hung up. He did manage to remove it and get himself to his house, and very fortunately we have rescue squads that were very effective, transported him to the Nebraska City Hospital about 20 minutes away, then ended up shipping him to St. Elizabeth in Lincoln with a specialist. He had three to four different surgeries, skin grafts at this point on his arms and he's doing real well. He's lost a little bit of feeling in his arm. Just note that agriculture is one of the most hazardous industries in the United States and things that we do need to be aware of. Their insurance premiums have risen $40 a month, and maybe that sounds minimal but $40 is $40. We also had an experience this past week with my brother-in-law using the health care system. He fell off a ladder and ended up dislocating and fracturing his shoulder and getting a concussion and so we used the 911 system which was recently put into our county. The QRT team, which is quick response team, was there from the local community, stabilized him, and within 15 minutes he was shipped by rescue squad.

Senator **Kerrey**. Rural volunteer?

Ms. **Boellstorff**. Rural volunteers we're talking about, yeah.

Senator **Kerrey**. Rural volunteer fire department?

Ms. **Boellstorff**. Rural volunteer fire department, rural volunteer quick response team, rural volunteer rescue squad. That's one of my solutions that the 911 system would be available to all people in all areas of the United States and that also maybe some assistance would be provided in the communities that do have volunteer systems, either a startup or assistance with equipment or training on local levels. Also affordability: In that 1980 collapse of the farm economy not only in Nebraska and South Dakota but throughout the Nation, people couldn't afford insurance. That was one of the first expenses that was taken out. People are sicker today because they couldn't afford a clinic visit, and to be diagnosed, they were brought in to the hospital.

Another accident: A young mother and daughter were in a car accident. The mother was killed and the daughter was seriously injured. Because of the farm economy, the husband had eliminated his health insurance and now they are in a lawsuit as far as who is liable for that bill. A man with polio couldn't get health insurance for pneumonia so he was not admitted to the hospital, and 2 days later he had respiratory arrest and hundreds of thousands of dollars were then used instead of that.

You talked about the Medicare system and the objectives as far as the balance according to that. Also, a young resident in our area talked about lifestyle being important. The time that Dr. Schlake was on call 80 hours a week of working that, that's a determining factor. More so even though than the money part of it as far as his colleagues are concerned at this point.

Assist the communities. Initiate the national 911. In an article by Richard Mangolas he talks about in American smalltown hospitals a patient isn't just a number, that curing and caring are one in the same, and I think that's the important thing that we need to consider with rural health care.

Senator KERREY. Thank you.

TEKAMAH-HERMAN SCHOOLS

STATEMENT OF KATHY CHATT

Ms. CHATT. My name is Kathy Chatt and I'm a school nurse for the Tekamah-Herman schools in Burt and Washington Counties in Nebraska. I travel between the two towns and I cover the health care needs of all 730 students in our rural school that covers grades and K through 12. I have been there since the fall of 1980, and I have seen our rural community like others go through hard times. Poverty in rural communities has been growing and has surpassed the percentages of poverty in urban areas. Poverty creates dysfunction in a family: the children and their health are affected. Poverty creates stress for the head of the household, and the children are abused physically, sexually, and mentally. According to the Nebraska Social Services, 29 of Nebraska's 93 counties have one out of every five children in poverty. Further effort has proved that children are the fastest growing sector of society to drop into poverty. ADC in the rural areas of Nebraska has risen 41.6 percent in the last 10 years. Children living in poverty and rural areas become the at risk students in the classroom, which coincides with many health risks. The national study regarding at risk students conducted in 1989 by the National Rural Development Institute found rural school children more prone to failure. Results showed rural students were more apt to be substance abusers, elementary children suffered more from depression, sexual activity was higher among rural high school students, preschoolers were more often victims of child abuse compared to urban children. This study alone coupled with the trend of poverty in rural areas shows the correlation between children in poverty and the health risks that result. Rural poverty has unique characteristics that differ from urban poverty. More often the rural poor have two parents working, rural income from that work is lower than the average urban income. They have a great majority self-employed. The rural occupations for the highest property rates are service, farming, forestry, and fishing.

The Congressional Budget Office report based on 1990 projects that if the current farm policies are continued, that farm income will decline $7 billion in 1995. This self-employment is not supplied with benefits. Working poor do not, therefore, have the health benefits and often cannot afford private health insurance. Rural poverty exists and I have seen its trail of destruction over the past years in the schoolchildren. Their self esteem has been taken to battle and is quite scarred. Their physical health shows lack of care by their neglect of good nutrition and unkept appearance. Society will pay higher health care dollars to pay for these children as they continue to live in poverty. Children need to learn that healthy minds and bodies are important. They need to learn how to make this happen. Children can be greatly helped with counseling in health education. Rural schools do not have enough counseling time for these children and there is not a comprehensive health education program in Nebraska. If a child would need health care, it would be hard to get ahold of the mother as they don't have a phone and financially they cannot afford medical costs. These children are at risk. They will become the pregnant teenager and drop out or may be a substance abuser. It would decrease our health care costs by providing education and counseling now.

Low self-worth encourages many health problems. It leads to depression, poor nutrition, poor immunity to colds and flu, and so forth. Research has indicated that low self-worth is the No. 1 factor among drug and alcohol abuse, discipline problems, delinquency, and teenage pregnancies. There are many with problems, and as the numbers increase, we still don't increase the counseling at our schools or provide comprehensive health education so that these students can make healthier decisions for themselves. Schools have the goal of education of the youth in the community and involve a great majority of each community in the staff. It is, therefore, in the school where help in the form of education and the physical and mental well-being could be monitored to ensure a healthy future for the coming generation. As a school nurse I have been utilized by parents and guardians for information for their children. They ask advice on what to do, when to see the doctor. At school we do hearing exams, eyesight evaluations, blood pressure checks, annual height and weight; we do not charge for this and the patient feels less intimidated by a school nurse than other agencies. Even when it would be apparent that the school nurse brought about child abuse intervention, the parents continued to communicate with the school. It is with great possibilities that the role of the health care professional could improve the health of the schoolchildren. The role of school nurse is vital for the children of our school. My function as their nurse provides lots of tender loving care that does much for self-worth improvement.

In the past 9-month period I have put on over 2,500 Band-Aids, used over 1,000 ice bags, gave out 2,100 cough drops for real coughs and some not so real coughs, numerous scrapes, put calamine lotion on hundreds of bites and poison ivy, monitored prescription medication, cared for children with asthma attacks, did head checks for lice, and the health room is a refuge for those who need it for whatever reason.

If a child is home ill, as a school nurse I can call to find out what is the illness and what is being done. And I always offer the school's help. We support social services in their work and also recognize that social services are overloaded. The role of the school nurse should be utilized even more to improve the quality of health care among children and also the schools could be a community source of health education. The funds for such activities in rural schools is a problem. My experiences as a school nurse have been bittersweet in nature. I have been given great rewards from children and parents alike. I have cried over the abuse and neglect I have seen grow in numbers over the past years. It is just not my rural area that has seen a change in our children's mental and physical well-being. Many others report similar concerns. I have attended conferences and workshops with other school personnel and found they report similar incidences. In some regions poverty is still a major issue in rural communities. Poverty causes health problems for our children, especially recognizing the fact that they are the fastest growing sector of society in poverty. By addressing poverty, we can aid rural health. By teaching good, healthy living, we use preventive measures. By utilizing the health care professional in the school, we can monitor the health of our children more efficiently. By providing community health outreach with a hotline, we can better meet the health needs of our rural people.

I want to stress to you that you need to take what information you have gathered today and call for action. If today's programs were completely successful and didn't need change, then we would not be seeing a rise in rural substance abuse among high school students. We wouldn't see a higher dropout rate of our rural children, depression among elementary students and more children who don't have self-worth as they should. Our children are a picture of what the future will be. I dream of children with healthy self-concepts raising their children to appreciate and strengthen the society in which they live. By working together, healthier minds and bodies will happen. Thank you.

STATEMENT OF KAROL OSTERLOH

Mrs. Osterloh. My name is Karol Osterloh and I'm here to ask you to provide health care to all in memory of our children. I'm speaking to you in memory of my daughter Pam, her twin sons, and all who have suffered and/or died as a direct result of the present American health care system. The purpose is not merely for a grade in my English class, but to raise the awareness of my brothers and sisters so we may unite, change the system, and prevent the tragic reoccurrence. God grant me the serenity to accept what I can't change, the courage to change what I can and the wisdom to know the difference. Pam's prayer.

The power of the people can and will change our health care system that is failing miserably to care for our women, children, elderly, and poor. Prevention is much more economical and humane than the expensive high-technology procedures that are employed to rescue those put into danger by lack of care. Prenatal care may be provided for as little as $400 to prevent low birthweight infants which will cost the U.S. health care system from $14,000 to $30,000. The 11,000 low birthweight babies born each year in the United States and the cost of each of these infants may reach a cost of $40,000. The 1987 death rate of American infants is 10.2 per 1,000 live births compared to Japan's 5 per 1,000 live births in 1986. If the United States could match the Japanese rate, the 20,000 children saved would contribute $2.6 billion in Federal income taxes in their lifetime. Programs designed and maintained to aid the needy are falling far short. The ones who need help are not being reached and others just don't meet the restrictive requirements. For every $1 Reaganomic's budget cut from the health care programs, the defense dollar increased by $4.15. The strength of our Nation lies not only in the strength of its military defense, but in the health and well-being of its women, children, and all citizens. Does not our destiny rest in the hands of our offspring?

"The Closest Thing to Heaven Is a Child," sung by the OakRidge Boys tells the story. Our cradles are empty or too often occupied by weak, small, inferior babies as compared to other nations. Some 40,000 American infants each year do not live to celebrate their first birthday. In 1986, 38 million Americans had no form of health insurance coverage and 36 percent of them were children, as stated by "A National Health Program is Necessary." Without insurance, women seeking prenatal care are denied access to such care unless they can meet the payments demanded of them up front by the greedy medical profession and the greedy clinics. Medicine is big business operated on a grand scale with one goal in mind, profit. According to a children's defense fund report, babies of mothers who received late or no prenatal care are three times more likely to die in infancy than babies whose mothers receive early prenatal care. Reaganomics on women has brought this about as a direct result of Federal health care budget cuts. The Federal Government cut programs and proclaimed a declining infant mortality rate, but it is misleading. The death of 11.3 per 1,000 is not a result of better prenatal care or prevention, but to higher technology intervention in hospitals. The children's defense fund notes that the death rate climbed in 11 States between 1981 and 1982. Mortality rates are as high as 59.5 per 1,000 live births. This is higher than Guyana, Panama, Tobago, and other poorer nations.

Washington, DC, loses more nonwhite infants than Cuba or Jamaica. Also, no or late prenatal care results in endangering the mother's life. This sad fact has brought the predicament of pregnant women home to me in the death of my 25-year-old pregnant daughter. Pam was a vital, energetic, and positive person. Behind every cloud she saw the silver lining. She always seemed to be an adult, for even as a small child she visited the older people on our block. She was ambitious, working every summer during her high school years. Pam and Marvin Breeze fell in love, married, and were a truck driving team for 5 years. She always wanted to see the country and she saw it through the windshield as they trucked coast to coast. We worried about her on the highway all those hours, but Breeze and Pam won several safe driving awards. The miles took their toll on the truck and the maintenance bills climbed faster than the revenue. Thus, they dreamt and saved for a new 18 wheeler.

In December 1989 a brand new 1990 Peterbuilt rolled off the assembly line with their name on it. A dream come true. Yes; it took every cent they could muster up, but it would soon return a good revenue. Pam also found out she was expecting their first child. Breeze will now wheel the 18 wheeler and I'll have my daughter close, as they bought a little house just across the street from me. Having Pam home and the added blessing of another grandchild on the way was an answer to my prayer. Pam is my middle child with two older sisters and two younger brothers. Connie and Shelley are married with two and three children, respectively. They are busy with their own little tribes, just as they should be. Scott and Brad, Pam's brothers, also have lives and interests as do all young men. That left Pam and I as she had no children to occupy her time and Breeze was on the road a lot. Pam would pop in for a few minutes nearly every day or give me a jingle on the landline. The only cloud on the horizon was the new trucking concern that had leased the truck failed to keep Breeze rolling. He would be laid over for 2 or 3 weeks at a time, yet the truck payments were rolling around. Shelley had a baby the same year as Pam became pregnant and she told Pam how very much she liked the woman doctor.

On January 10 Pam had her first visit with the doctor. At this time it was revealed that unlike Shelley, Pam had no insurance. Apparently the fee for prenatal care would have to be paid up front before Pam's next visit. Pam made the appointment for February 28 extending it to the very end of the month thinking, of course, that by this time the new truck would easily have returned the $800 she needed. It didn't happen. March, Pam tried again and made another appointment. At this time she had $400, one-half the fee. The door once again was slammed in her face. Pam was poor, white, and proud. She thought she could handle it all by herself, and God forgive me, I thought she could, too. I thought I was doing the right thing by raising my kids to be independent and not interfere. Pam landed a couple of part-time jobs, but the money she earned always had another destination. Pam painted furniture for the baby's clothes, removed paneling and painted, converted their office into a nursery. She called me to come see how nice it looked. I had to smile to myself as I watched her prepare her nest. Sometimes Pam would complain a little about getting up a lot at night and her feet began to swell. She had a little cold and her sister Connie, who at this time was pregnant and also seeing the lady doctor, had a cold as well. Pam wouldn't take anything for her cold fearing it may harm her baby. Connie and Pam went shopping and Connie told her what the doctor had told her to use for her cold and so Pam did the same. The doctor would see Connie, for she had insurance. Pam also stopped eating salt hoping this would prevent the swelling. The swelling kept getting worse and everyone was becoming concerned. Shelley told the doctor when she treated Shelley's son's broken finger that she is really worried about her little sister, she is really swelling up and becoming numb on one side. The doctor said, when you are large, pregnant, and lay on one side all night, this may happen. This doctor's visit took place on March 19, 1990. Pam told me she didn't feel well and was sometimes sick to her stomach. She still had a little cold. Pam's words will echo forever in my mind, "As old as I am, when I'm sick, I want my Mom."

One night Pam popped in for a moment to show me her hair. She had put a rinse on and it turned a bit orange. Pam's crowning glory is her pretty, thick long blond hair. She was good at cutting hair and after high school attended beauty school. She thought if she fixed her hair she'd feel better. I always feel the same thing, it just makes a woman feel better. On this visit Pam said the doctor would not return her calls and since Pam wanted to see only this woman doctor, I suggested she tell them it is an emergency. You need fluid pills, I told Pam. I had previously suggested Pam call our old family doctor and explain her predicament: 7 months pregnant, her physician would not see her, and ask him for a prescription for fluid pills. This is the last time I saw my daughter alive. We chatted on the phone the last time on Friday, April 6 and Pam told me she had the money and an appointment with the doctor on April 9. I asked why she didn't see her that Friday and Pam replied, "She isn't in." Why don't you see her Saturday then, I inquired. Again Pam replied, "She isn't in but I'll see her Monday."

Sunday, April 8, after Pam did not return Connie's and my phone calls, Connie and I went to check on her. We found our Sunshine lying on the floor, dead and no chance to save her or the twins she carried. The doctor Pam had not been able to see was contacted on the day of Pam's death by the investigating officer. He obtained her unlisted phone number and here is what she told him, "I have had no messages from Pam." Connie and Shelley had both expressed their concern for Pam's welfare to this very doctor. Pam's phone bill listed four calls from Pam's to the doctor's office from April 3 through the 6th, at which time Pam managed to make an appointment. Some doctors claim the high cost of medical treatment is caused by the high cost of malpractice insurance. It looks to me as though the medical profession's incompetency and neglect of their patients is a very real contributing factor. Insurance companies say the high settlements they are required to pay out are the reason for the high rates. They have gone so far as to print guidelines for doctors to follow so as to prevent claims. Insurance companies instructing the medical profession on how to conduct their business? Are the doctors so lax in their care that it has come down to the responsibility of the insurance companies? No one expects the medical profession to work without compensation, but how much is enough? Why not the sliding rule to include people such as Pam, who just don't have the means, at the time, to meet the high costs of medical care? I have three daughters and all three went to the same clinic and the same woman doctor for prenatal care, and Pam is the only one denied prenatal care after her initial visit. She is also the only one not covered with insurance. The doctor claims she has nothing to do with the front office policy on admitting patients, yet another medical doctor working for the same clinic says he makes sure his patients get in for their prenatal visits, regardless of ability to pay or insurance. He also said because of Pam's weight and the fact that she is a smoker, she was a high-risk patient. He said Pam's death should never have happened. He may not say any more for his higher-ups let him know that his job is on the line. His position is on the line, but how many lives, like Pam's are on the line? Pam's sisters and I had talked her into letting us give her a baby shower after the baby came but we ended up writing thank you's for her funeral.

I'd just like to say that in Canada no one is ever denied medical care and in 1985 we spent $1,500 per capita in personal health expenditures whereas Canada spent $1,010 also providing universal and comprehensive coverage. Something is definitely wrong with our system. There are too many people like Pam who do not qualify for the health care programs and yet Pam was a contributing taxpayer, she paid income taxes, she paid all these taxes and yet when she needed help, they weren't qualified.

Senator **Kerrey**. Thank you.

Senator **Daschle**. I would like a copy of your testimony.

Mrs. **Osterloh**. This is my daughter, Connie. She is expecting a baby in November and she saw the same woman doctor. She's never had any problems. She can always make an appointment, and her sister's baby is 8 months old and the woman doctor delivered that baby and she can always make an appointment to go see her. She is also insured. Thank you very much.

Senator KERREY. Thank you very much.

STATEMENT OF DAN SHELLPEPER, STATE SENATOR FROM NEBRASKA

Senator SHELLPEPER. Senator Kerrey, Senator Daschle, I'm State Senator Dan Shellpeper. I want to thank you for coming to hear our concerns and ideas about the future of rural health care in Nebraska.

Rural health care is one of the most difficult issues facing this State because so much depends on health care. Nebraska is predominantly rural and its farmers make up the backbone of this country's breadbasket. They need and deserve quality health care if this State is going to continue to grow and prosper.

One of the biggest problems is the lack of physicians and nurses in rural areas. At last count more than 40 rural Nebraska communities were actively seeking a physician. I introduced legislation to continue the Nebraska Rural Health Manpower Act which provides loans to medical students who agree to practice in rural areas. However, there are too many communities that need help for this program to take care of the physician shortage by itself. We also need nurses throughout the State. A survey by one of the nursing home associations indicated that more than 900 additional nurses would be required just to staff their facilities by October 1, 1990, when a new OBRA requirement goes into effect. This affects hospitals and rural clinics as well as nursing homes. I strongly support Federal efforts to get more physicians and nurses into rural areas. Getting the National Health Service legislation passed would help a great deal. The support that this bill will provide to physicians would make rural practice much more attractive.

I also support including assistance for Offices of Rural Health. The Nebraska Legislature passed a bill which I introduced to create the Office of Rural Health. This office will help rural communities deal with the health care problems that they face. Additional funding is needed to find creative methods of dealing with these problems.

The difference in Medicare and Medicaid reimbursement between urban and rural areas needs to be eliminated. The reasons for justifying the difference just do not make any sense. It costs just as much to provide health care in rural areas as it does in urban areas, and physicians and hospitals should receive the same reimbursement for the same kind of care regardless of where they are located.

More efforts need to be made to deal with the nursing shortage. I worked to get legislation passed to provide scholarships to rural, nontraditional students who want to go into nursing. This type of scholarship program has the best chance of succeeding since it will be used by people who will return to that community since they already have ties there. This legislation, LB 520, also provides incentive payments to nurses who return to practice in rural areas. I think that we need to be willing to try new approaches just to deal with these problems. We need support for these programs.

Once again, I appreciate your interest and your work in this area and would be glad to do whatever I can on the State level to assist you in your efforts.

Senator **Kerrey**. Thank you very much, Dan. I appreciate your interest.

Senator **Shellpeper**. Nice to be here.

Senator **Kerrey**. Just checking with Senator Daschle, he doesn't mind spending a little longer, too, I would like to try to get three or four more people and then reiterate what I said at the start, that any additional testimony can be submitted for a full week after this hearing today, in writing, and will be a part of the record, and I greatly appreciate it as well. Staff has just indicated that we actually need three copies of the testimony, if that's possible.

Ruth O'Neal from Clarkson, I think it's Dr. Judy Butler, Diane White from West Point and Don Hruza from North Bend.

STATEMENT OF RUTH O'NEAL

Mrs. O'**Neal**. I have only one question. I think everything else I wanted to say has been——

Senator **Kerrey**. For the record, just——

Mrs. O'**Neal**. Ruth O'Neal from Clarkson.

Do to the Medicare age Senators—or Congressmen, I should say, abide by the DRG's when they are hospitalized? If they don't, why don't they?

Senator **Kerrey**. Do we abide by them?

Mrs. O'**Neal**. Do the Medicare age Congresspeople when they are put in a hospital, are they required——

Senator **Daschle**. To my knowledge.

Senator **Kerrey**. Although it would depend on what hospital they go to. If they go to any Government hospital, then they would not. Veterans Administration, for example, doesn't. If somebody were to go to Walter Reed, they would not. But in all other situations, they would be under the DRG's. And I think, although I'm not sure of this, that most people in Congress would go to the private hospital, not to the VA or to Walter Reed.

Now, if you'd ask me, "What does the President of the United States do," the President goes directly to Walter Reed. He doesn't live under the DRG's. We give the President socialized medicine.

Mrs. O'**Neal**. Alright. Thank you.

STATEMENT OF DR. JEANNIE BUTLER

Dr. **Butler**. Thank you. I'm Dr. Jeannie Butler, and I do family practice in rural Nebraska and I have been out there about 7 years and have been through this disastrous change. I think medicine is under siege, it's a profession that is at war and I think that rural doctors are in the trenches. It's awful out there and has gotten so much worse in the past 2 years and it's emerging now.

They lost 40—he told you they lost 29 this year. They lost 40 in 1988. The data from 1989 hasn't been counted and it's getting worse dramatically. It's in part payment and then in part the proliferation of regulation, the denial of our patient admissions and the intensified review and the intensified activity of PRO in rural areas. We are just not getting the data to support that and I will submit that to you in writing. It's just gotten so much more intense that it is intolerable for these young people and old people. The young doctors that are going out there have the same training as their urban counterparts. Those people in Lincoln never hear from a PRO, they don't know. And they get paid twice as much. For twice the work, twice the stress, we get more harassment and less pay. Now, and that's the immediate problem.

Medicine in this country is following the same line because of the proliferation of regulation. You asked before about solutions. First of all, your comment that only 5 percent costs for administrative Medicare, I don't know who does your figuring, actuarial analysis, I don't know how that's possible. Some of the data I have read started at 22 percent. It increased 25 percent last year and that's not counting the 15 percent increase in the cost of my overhead in the past year, and 50 percent after 3 years just to do Medicare and PRO activity, so somewhere, somebody's not getting——

Senator **DASCHLE**. I'm talking about within the Federal agency itself, I'm told that the administrative cost for Medicare internally is 5 percent. That doesn't mean the costs they pass on to you.

Dr. **BUTLER**. Well, I don't know how that's possible. They must—I don't know which desks or which accounts they are picking out, but the material that we had gotten was it was 20 percent and we will have to go back and look.

Senator **DASCHLE**. Twenty-two percent of all health care in this country is administrative cost.

Dr. **BUTLER**. Yeah, that's right.

Senator **DASCHLE**. Of all of it.

Dr. **BUTLER**. Well, I think you need—anybody that's in a regulatory position starting at the very top needs to give to you—I think you go out to set the law in the best interest of the people. I know you do, but I think when it gets to the regulatory agency, you lose control. Nobody reports to you the impact of their regulation. I don't think the regulatory process is in the best interest necessarily of democracy and what you are doing. I think you lose control. They don't have to report to you the fiscal impact, the impact on lives, when it happens to health care, the impact on rural Nebraska. What does it do? And that regulatory process has to stop. I mean, proliferation has to stop and they have to account to you for those regulations. I think it's happening in farming, banking, business and not just medicine. I think if you just did that, you save a lot of money and stop at least this escalating disaster that we're facing.

The Canada system, one-payer system is not all that great. The availability for you as you get older of the technology is not there. You get over 65, you don't get your bypasses and your angiograms, you wait for 6 months for CAT scans. Things that the American people haven't had to do, and I'm not sure that they would want to do that if they knew that's what they had to do.

Senator **KERREY**. Thank you.

STATEMENT OF JIM BANARK

Mr. **BANARK**. Hi. My name is Jim Banark and I'm a consultant for long-term care nursing homes, and since Don decided to bow out, I decided to take over because I think this issue has been neglected today.

Our panel did not include anybody from long-term care. Since there are 250 nursing homes in Nebraska and about 15,000 across the country, I feel this issue should be spoke upon since we have more regulations than hospitals do.

Some of the issues that I'd like to talk about, first of all, I have been able to work in a lot of different areas. I have been consulting for 3 years and I have worked in rural Kansas. I have been to Woonsocket, SD, and all over Nebraska, Iowa, and even the suburbs of Chicago and Kansas City, so I have been witness to what's going on out there and what we're seeing is the regulations with the OBRA, for example, increasing the quality of the care for these patients, which we don't have a problem with, but we don't see the reimbursement rates coinciding with those changes in the regulations. We have nursing shortages, of course, like everybody else, but we are not getting the reimbursement rates that the hospitals are getting.

In Nebraska we are going to have waivers for nursing homes. The nursing homes are now going from intermediate care to skilled care effective October 1. They are all going to be skilled care, so competition is such, all of these rural facilities are going to start taking patients who are with NG tubes, trachs, maybe even respirators. Some of these cases, you will have these patients scattered out and the cost is going to be more expensive than locating them in skilled facilities.

The nursing home reimbursement for Medicaid is 35 percent lower than that of hospitals as far as nursing home costs. For our nurses, we're competing with hospitals. We're seeing the cost for a registered nurse in Omaha go from $7.50 an hour in 1985 to $15 an hour, and that's in 5 years. The reimbursement rates aren't going up along with them.

A few other things. I would like to recommend that you support House Representative Terry Sacorski, if I'm correct, and Senator David Pryor in some of the amendments they are putting onto the OBRA regulations. And I would also like to note that Senate Resolution 125, which I am not familiar with, but I was told has to do with long-term care reimbursement and quality and the standards versus the reimbursement rate, we would like to see a signed Senate resolution.

Pat Schneider, who is our association director, will be in Washington June 11 and would like to talk to Senator Kerrey about those issues.

Other things we are seeing in long-term care with these regulations—to show you what we are having to deal with—is all of a sudden we cannot do a glucose test because we are not a laboratory, which is a common practice in a nursing home. You can do it in your own home, but you cannot do it in a nursing home because you are not certified as a laboratory. This goes into effect, I think, October 1. This is what they are saying.

Also, and this has nothing to do with health care, but we are going to have to pay a licensing fee to show home videos to our little old ladies and our old men. I mean, the regulations are getting out of hand. The cost of reimbursement is not coinciding with it. We have more regulations than any other business there is, except nuclear powerplants, and part of this is our own fault.

Senator **Kerrey**. Do you have guns?

Mr. **Banark**. Oh, I don't know about that, but part of this may be our own fault. You know, the average voting age is over 55 so they carry a lot of clout when it comes to this stuff, and we understand that and we want the quality. The mom and pop homes are over with. You are seeing more professionalism. We want quality time. We can't do without the reimbursement rate, and 50 percent of the people in Nebraska are on Medicaid.

Dr. **Butler**. And the regulations that affect him make it 10 times harder for me because if I can't get that check, how am I going to take care of that patient? That's another extreme frustration in rural health care. You are dealing with the regulatory problems in taking care of elderly patients. It's just an impossible situation.

Senator **Kerrey**. I know that, I know that Senator Daschle is very familiar with Senator Pryor's amendments as I am as well.

In fairness, Dr. Wright was trying to pack 1 hour's worth of testimony in 5 minutes. One of the last things he had on his list as well was the need to reform OBRA, and that is going to be a pressing concern, although I use this as an opportunity to transition into my closing remarks.

It seems to me one of the most important questions, whether you develop a new and more comprehensive way to finance health care, which I happen to think you need, by the way—otherwise, you are going to end up with more regulation—but whether you do that or not, it seems to me one of the more important questions to ask and to answer is how are we going to organize the distribution of what we have?

I'm painfully aware of the administrative power and the real power that the Health Care Finance Administration has. They now control about 20 percent of every health care dollar that's spent in America, and I know that when people come to see me in Washington on health care, they see me second and go to HCFA first, and nobody elected HCFA to do anything.

And what we have done with the DRG's, I think it's good in theory, we have rationalized health care in a manner that I think for the most part has provided people an incentive to be more efficient. It's not worked very well in rural America but one of the things that it has also created is a massive Federal bureaucracy and a top down regulatory mechanism that is the worst kind of regulatory mechanism of all to have in place. It seems to me one of the things we have got to ask is whether or not we advance to a much more comprehensive way of financing health care so that we can, in fact, relieve people of the burden of wondering whether or not they have got anything at all and eliminate the terrible example that was offered up here a few minutes ago. That is not, by the way, a single incidence. It occurs in long-term care facilities, it occurs in acute care operations, and it occurs too often.

It's needless, it seems to me, when we are spending $650 billion a year, for that to happen. One of the reasons it happens is we have got excessive administrative costs. One of the reasons I think we have got to cut the administrative cost is the way that we have organized the system. So a key issue is how we should organize it.

Particularly given some of the things I heard in the second panel that came up here about what local communities are trying to do, what volunteers and other individuals are trying to do with their own efforts, I have a very strong preference for organizing these things from the bottom up rather than from the top down.

Again, I want to thank all of you for providing testimony. The record will stay open for 1 full week. I want to thank my friend Tom Daschle for coming here as well and give him an opportunity to make a closing statement.

Senator DASCHLE. Bob, I just want to associate myself with your remarks. I think you are absolutely right; we have to look at the system and how we organize that system. You have been given a lot of different perspectives about that system today and I think there is a lot of agreement. And as we look at how we can find a consensus in health care, it goes back to addressing those three fundamental questions: How do we improve quality; how do we improve access; and how do we contain costs? I think that we have got an even more severe problem in rural America than we do virtually anywhere else in the country.

We have seen some real leaders here who are putting out a tremendous effort in providing the best health care they can under the circumstances. The problem is the best isn't satisfactory enough in many cases, and Karol Osterloh gave me all the reason I needed to come down here and to take back her testimony and share that with everybody in Congress. They ought to hear that. They ought to be fully aware of the consequences of doing nothing. We simply can't afford to do nothing. We have got to address this issue more effectively and this hearing certainly has given us an opportunity to acquire the ammunition necessary to do the right thing. Thank you all very much, and Bob, thank you.

Senator KERREY. You are welcome. I need to thank the Fremont Senior Center for having us here, especially Doris Anthony. We overstayed our welcome a bit and I appreciate very much your cooperation.

I also will take advantage of the opportunity of having the last word to say that I think it's very important, at least for me personally, to acknowledge that most of us do get pretty darn good health care. JoEllen Vrbka in her testimony gave an awfully important anecdote in describing the treatment that her father got for a heart attack and her brother got for a heart attack.

Though we may not apply technology in every single instance correctly, I think there is no mistaking the fact that the advance of technology and medical science has improved the quality of our lives as well. I know that my life was saved personally in 1969 as a consequence of extraordinary health care in this country, but it was also saved as a consequence of extraordinary generosity on the part of Americans who made darn sure that the Naval Hospital in Philadelphia was first rate. It took dedicated doctors, it took dedicated nurses, it took modern science, but it also took a committed country and citizens to simply say that, "If you get blown up in Vietnam, we're going to take care of you." Basically all I've tried to suggest, if I have suggested nothing else in this afternoon's testimony, is that I think we need to raise the threshold a bit to include more teamwork. Thank you very much.

SUBCOMMITTEE RECESS

This concludes today's hearing. The subcommittee will recess until 1:30 p.m., Sunday, June 3, at the Panhandle Research and Extension Building, Scottsbluff, NE.

[Whereupon, at 5:15 p.m., Friday, June 1, the subcommittee was recessed, to reconvene at 1:30 p.m., Sunday, June 3.]

RURAL HEALTH AID

SUNDAY, JUNE 3, 1990

U.S. Senate,
Subcommittee on Agriculture, Rural
Development, and Related Agencies,
Committee on Appropriations,
Scottsbluff, NE.

The subcommittee met at 1:30 p.m., at the Panhandle Research and Extension Building, Scottsbluff, NE, Hon. J. Robert Kerrey presiding.

Present: Senator Kerrey.

Also present: Senator Daschle.

NONDEPARTMENTAL WITNESSES

OPENING REMARKS OF SENATOR KERREY

Senator **Kerrey**. I appreciate you taking the time on a Sunday afternoon to come out to discuss a very important subject: That is, health care in Nebraska, and specifically the problems that Nebraska is facing with rural health care. We are interested in both access to health care and the cost of health care, as well as the quality of health care. All of these are increasingly becoming very, very difficult issues—life and death in some cases—for individuals, families, providers, and businesses.

It has become extremely costly for patients who are purchasing insurance on their own as well as businesses who are purchasing coverage for their employees. It has become increasingly difficult to providers as well as they try to comply with a multitude of rules and regulations.

I will stop without going a great deal further. Senator Tom Daschle and I are holding these hearings on behalf of the Senate Appropriations Committee. I just gave my remarks and our questioning may be a bit brief. Senator Daschle has a plane to catch out of Omaha, and so we are going to try to keep this as close to schedule as possible.

I appreciate his coming very much. We learned a great deal in the three previous hearings. I do not expect this one to be an exception. I would like to call on Senator Daschle now.

STATEMENT OF HON. THOMAS DASCHLE

Senator **Daschle**. I want to be very brief as well. I would only make three points.

First of all, this is an unusual opportunity for us to try to determine as best we can the state of rural health and what we ought to do about it in the future.

The second point is that I want to thank you for sending the likes of Bob Kerrey to Washington to work on this issue. There are very few people with his knowledge and his determination to address these problems. He has been a very good friend of mine. We find we work on these issues very effectively together, and I am pleased to join him here in Scottsbluff. He is a remarkable leader, especially when it comes to the issues of rural health.

The third point I would make is that the Congress finds itself like a fire department. We are always putting out the hottest fire first, and there are a lot of hot fires out there when it comes to rural health. We do not have many primary care physicians. Our rural hospitals are being threatened. As we look to access, cost, and quality issues in rural America as they apply to health, we have got some of the most severe problems we face anywhere in the country.

We have to address these problems, and I hope we can put the fires out and begin dealing with fire prevention. That is, to look prospectively at some of the things we have to do to address these issues more effectively; to ensure that we have primary care physicians, to ensure we have good facilities, to ensure we can keep costs down, and to ensure that in the long run we have a lot better system than we have today.

If we do not do that, I really fear for the quality of life in rural America. That is what these hearings are about. I hope we can get the job done.

Senator KERREY. Thank you, Tom. I will emphasize that it is an official Senate hearing. There is a transcriber that will be taking notes, and it is very valuable, therefore, if you could just state your name and address. It sounds a bit perfunctory but it is important for getting the record complete.

Since something may be sparked by what is said and someone may want to make further comments or if someone who is not able to attend today wants to give testimony, the record will stay open for a full week after this hearing today. Testimony may be submitted either through Senator Exon's and my office here in Scottsbluff, or by directly going to Washington. It will become a part of the record if submitted within 1 week from today.

With that as a preliminary statement, I will call on the first witness. So we can get through all the witnesses that are here and anyone else who may come to an open microphone later I would ask that you try to keep your remarks in line with a light that is going to go on here when time is up. It is not one of the 10 Commandments and feel free if the light goes on to just make an effort to summarize at that point. There is plenty of time to get the testimony in.

The first witness is Terry Null from Scottsbluff, a patient with multiple sclerosis. I thank you, Terry, for coming here. I appreciate your willingness to come and testify.

STATEMENT OF TERRY NULL

Mrs. NULL. Thank you. Terry Null, 2202 Avenue O, Scottsbluff.

I would like to address two issues from a patient's perspective on health care for rural Nebraska.

The first is the care that is received. The second is the filing and collecting under insurance.

I am Terry Null, and I have multiple sclerosis. I was diagnosed 19 years ago. My particular type of MS is a chronic progressive disease. I depend upon Home Health through Regional West Medical Center not only for my care but for insurance filing with costs being reimbursed through insurances.

I require skilled nursing care and physical therapy weekly. Home Health shines in these two departments, and I receive excellent care. The area that I am most concerned about is attendant care. Certified nursing attendants required so many hours of training which is provided by the hospital, and those attendants are paid minimum wage. After training and some working experience these attendants find it more lucrative to go out and work privately on their own.

Therefore, we are understaffed at our hospital. There are not enough attendants to care for individuals. I do require daily attendant care, and I am not receiving it. I cannot get out of bed, go to the toilet, bathe, and dress myself without assistance. Without attendant care, I have been forced to give up so many things I enjoy and love doing.

The main focus of Home Health care now is either children or the elderly. I am neither so I fall into a gap. I depend on the Handi-Bus service for transportation providing I go between the hours of 8 a.m. and 4 p.m. and not on weekends.

Having a catastrophic disease is a big financial burden. I cannot afford to privately pay for attendant care or transportation. I need a lift van and cannot afford one. I cannot depend upon my husband because of his physical limitations, and he works out of town. I feel that I am too young to go to a nursing home, yet I am not well enough to live independently by myself.

I am not only speaking for myself but for other handicapped individuals. We fall into the gap. What can we do about it? How can we change it? How can we make the system work for us?

The second issue I would like to address is the filing of insurances. This is a monthly task. This is difficult and timely and filing with Medicare is literally a paper battle. I do the best I can and have to employ an individual from Home Health that does nothing but Medicare filing. She has to call on me at my home several times a month for proper filing, and I am only one individual receiving care from them.

Home Health Medicare tells me they are my secondary insurance carrier. My primary insurance carrier is covered through my husband's employer. I first file my Home Health care costs with my primary carrier, and under the policy I am allowed so many visits per calendar year. This insurance covers 80 percent, and Medicare covers 20.

My primary carrier rarely processes my claim correctly. I have constant written correspondence, requests, and long-distance phone calls to straighten out proper payment. The Home Health clerk does the same thing. Then we have to follow up with payment verifications in the billing department.

In turn, Medicare is then filed. The barrage of paper with Medicare is overwhelming. On my lap I have a folder of pending paper work that I am waiting to hear on. Medicare paid on my first claim of June 1989. In May 1990 Medicare is backlogged 12 months in processing claims.

I filed an equipment claim for a wheelchair purchased in November 1988 with Medicare twice because Medicare said those papers were lost. The third filing was sent registered mail. Medicare denied payment. The claim was resubmitted, and Medicare requested additional forms. This claim is still pending upon filing of Medicare.

I never know where my claims might go. It might be Iowa, Texas, Kansas City, or Minneapolis. I also find Medicare denying every first claim. Why is this so? Why does a patient have to file, refile, resubmit every claim with Medicare? Think of the hours of manpower logged to this process. It is most difficult for me to keep up with this paper battle. I simply do not know what some handicapped people do for their coverage, and I cannot fathom our senior citizens doing this kind of paper work. People must give up and like me go ahead and privately pay the balance.

We need to make some revisions on Medicare payment when certain aids or equipment are needed. I find it hard to believe that a shower bench or a chair or grab bars around the toilet are not covered by insurance, because they are not considered necessary but cosmetic.

I feel like I have a good perspective on this situation, and I feel that I can speak not only for myself but for a lot of other handicapped individuals. We need to be concerned about the care we receive or the care we do not receive simply because we fall into the cracks. How do we correct this? What do we do for those of us that need attendant care? We need that equipment or transportation. We cannot privately pay for it on our own. We have insurance, yet it is not being covered.

We are being bogged down with paper work, and yet we cannot collect. It is a burden financially to those of us with chronic progressive disease; however, let us not forget that we are members of families. We have spouses and children. We have to provide homes, raise and educate children, and provide all the basic necessities of everyday living. When we have a financial burden of this kind, why it is such a problem that we are forced to take away from our families our basic or individual needs. What are the answers and how do we fix it? I thank you for your attention to my concerns, and I hope that together we can find some answers.

Senator KERREY. Terry, do you have some suggestions since you have obviously labored under this paper work problem? Do you have some suggestions as to how it could be simplified?

Mrs. NULL. Firing about one-half of the people in the offices and hiring a whole bunch of gals that know what they are doing.

Senator KERREY. Which half?

Mrs. NULL. I would be happy to be the director of Medicare. I find it overwhelming that this is the paper that I am sitting on. I know with every sheet of the paper that I am sitting on comes 5, 6, 7 sheets from the care givers, from the nursing staff, and the documentation that is needed, not to mention the doctor's written requests and forms. I do not know the answer.

Senator KERREY. Let me lead you a little bit toward an answer, though I have not actually come to a detailed conclusion. The current form that was selected for the administration of Medicare is a top-down form. In other words, it is located in Baltimore, MD. That is where the administration of Health Care Financing Administration is located, and they control approximately 30 percent of health care expenditures in the United States of America.

This is a top-down method of operating, compared, for example, to education where it is supposed to be the other way around. In fact, most of the expenditures made on education are controlled either at the local level or the State level. The Health Care Financing Administration is just the opposite.

So the question that I have been struggling to answer, and you might be able to help me, is whether or not there might be some way that we could reverse at least part of those financing decisions, because this is essentially a financing decision.

Mrs. NULL. Correct.

Senator KERREY. You are putting in a request to pay either for transportation, home care or some kind of equipment. The question then becomes: Is Terry eligible? They answer you are eligible and decide how much is going to be paid out. Those are the sorts of things that are going on. What is happening now as you are filling the forms out, you are mailing them back to Baltimore, MD, basically, where the decision ends up getting made. Even if it is made by some intermediary along the way, that still does not take away the central responsibility that HCFA has got.

The question is whether or not it is possible to reorganize it. A reorganization could make administration possible at the local level. I suspect if we did that it could be done more quickly, and probably much more effectively as well.

Mrs. NULL. Maybe we ought to keep our claims within the State of Nebraska, within a localized area.

Senator KERREY. That is possible: that could occur and would make it better. However, having experience with State regulations as well, I am not convinced anyone would say putting it in Lincoln, NE, would be an improvement over Baltimore, MD.

It may be what we are looking for, in fact, is something even more local than that. Where you are looking straight face to face with the person that is making the decision.

Mrs. NULL. Right.

Senator KERREY. Or close enough that you get a decision being made by somebody who knows who you are, knows that what you are buying, and knows what the cost is, and that sort of thing.

Even if we could get the 50 percent of the people not doing well replaced by people that are good, the problem is there are people out there making decisions about things they really know very little about and doing it so remote from the point, in this case Scottsbluff, that I am not convinced that no matter what we do with personnel in Baltimore, MD, that it would improve what we have got in place.

Mrs. NULL. Correct. Plus everyone is an individual.

PREPARED STATEMENT

Senator **KERREY**. Yes; thank you. We have your prepared statement and it will be made part of the record.

[The statement follows:]

STATEMENT OF TERI NULL

I would like to address a two-fold issue as a patient's prospective on health care for rural Nebraskans. The first being the care that is received. The second being the filing and collecting under insurances.

I am Teri Null and I have Multiple Sclerosis. I was diagnosed 19 years ago. My particular type of MS is a chronic progressive disease. I depend upon Home Health through Regional West Medical Center not only for my care but for insurance filings with costs being reimbursed through insurances. I require skilled nursing care and physical therapy weekly. Home Health shines in these departments and I receive excellent care.

The area that I am most concerned about is attendant care. Certified nursing attendants are required so many hours of training, which is provided by the hospital, and those attendants are paid minimum wage. After training and some working experience these attendants find it more lucrative to go out and work privately on their own. Therefore, we are understaffed in our hospital. There are not enough attendants to care for individuals. I do require daily attendant care and I am not receiving it. I cannot get out of bed, toilet, bathe, and dress myself without assistance. Without attendant care I have been forced to give up so many things I enjoy and love doing.

The main focus on Home Health care now is either children or the elderly. I am neither, so I fall into a gap. I depend on the Handi-Bus service for transportation, providing I go between the hours of 8:00 a.m. and home by 4:00 p.m., and not on weekends. Having a catastrophic disease is a big financial burden. I cannot afford to privately pay for attendant care or transportation. I need a lift van and cannot afford one. I cannot depend on my husband because of his physical limitations and he works out of town.

I feel that I am too young to go to a nursing home. Yet, I am not well enough to live independently by myself. I am not only speaking for myself but for other handicapped individuals. We fall into the gap. What can we do about it? How can we change it? How can we make the system work for us?

The second issue I would like to address is filing of insurances. This is a monthly task. This is difficult and timely and filing with Medicare is literally a paper battle. I do the best I can and have to employ an individual from Home Health that does nothing but Medicare filing. She has to call on me at my home several times a month for proper filing and I am only one individual receiving care from Home Health.

Medicare tells me they are my secondary insurance carrier. My primary insurance carrier is covered through my husband's employer. I first file my health care costs under my primary carrier and under the policy am allowed so many visits per calendar year. This insurance covers 80 percent and Medicare 20 percent of costs. My primary carrier rarely correctly processes my claims. I have constant written correspondence, requests, and long distance phone calls to straighten out proper payment. The Home Health clerk does the same thing, then we follow up with payment verification in the billing department. In turn, Medicare is then filed. The barrage of paper with Medicare is overwhelming. Medicare paid on my first claim of June 1989 in May of 1990. Medicare is backlogged 12 months in processing my claims. I filed an equipment claim for a wheelchair purchased in November 1988 with Medicare twice because Medicare said those papers were lost. The third filing was sent registered mail. Medicare denied payment. The claim was resubmitted and Medicare requested additional forms. This claim is still pending.

Upon filing of Medicare, I never know where my claims might go. It may be Iowa, Texas, Kansas City, or Minneapolis. I also find Medicare denying every first claims. Why is this so? Why does a patient have to file, refile, and resubmit every claim with Medicare? Think of the hours of man power lost to this process. It is most difficult for me to keep up with this paper battle. I simply cannot know what some handicapped people do for their coverage and I cannot fathom our senior citizens doing this kind of paper work. People must just totally give up and like me, on so many claims, just go ahead and privately pay the balance.

We need to make some revisions on Medicare payment when certain aids or equipment is needed. I find it hard to believe that a shower bench or chair and grab bars around the toilet are not covered by insurance because they are not considered necessary but cosmetic.

I feel I have a good perspective on this situation and I feel that I can speak not only for myself but for a lot of other handicapped individuals. We need to be concerned about the care we receive, or the care that we do not receive, simply because we fall between the cracks. How do we correct this? What do we do for those of us that need attendant care? That need equipment and transportation? We cannot privately pay for it on our own, yet we have insurance and it isn't being covered. We are being bogged down with paper work and yet we cannot collect.

It is a burden financially with those of us with chronic progressive diseases. However, let us not forget that we are members of families. We have spouses and children. We have to provide homes, children to raise and educate, and provide all the basic necessities of every day living. When we have a financial burden of this kind why is it such a problem that we take away from our families or basic needs or individual needs? What are the answers and how do we fix this?

I thank you for your attention on my concerns and I hope that maybe together we can find some answers.

Regional West Medical Center

STATEMENT OF ELLEN PUTNAM

Senator **Kerrey**. The next witness we have is Ellen Putnam, utilization review person with Regional West Medical Center here in Scottsbluff.

Ms. **Putnam**. I am Ellen Putnam, 2209 Avenue E in Scottsbluff, NE.

Thank you for coming to Scottsbluff and for allowing us the opportunity to share with you our concerns and potential for solutions to the problems we face in health care delivery.

Over the past few years hospitals, physicians, and patients have had to contend with an ever-changing health care system. These changes have included an increase in the complexity of the system, the criteria based for the various levels of care, a limited supply of resources in rural areas, and a limited understanding by the public attempting to use the system.

These in turn have led to a fragmentation of health care, a loss of patient rights of choice, and a loss of the personal human touch. We often see elderly people, who marginally manage at home, seeking medical attention from their family physician or in an emergency room when they become ill. They may not be ill enough to meet the criteria for hospitalization, yet may be too ill to care for themselves at home.

The dilemma then exists of when and how to prepare care. The severity of their illness and the intensity of the service they require does not necessarily match the admission criteria for acute care. They have not met the 3-day acute care requirement for Medicare to reimburse at the skill level. Their level of care may meet the intermediate criteria, but that level of care will not meet the needs of an incubating illness.

They also may not have the financial resources to pay for the intermediate nursing home care. Medicare does not cover intermediate care and patients view nursing home care as the last stop before death. They prefer staying in their own home, but resources within the family may be very limited to provide physical assistance.

Home Health and Homemaker Services are available in some areas but not in others. Patients may decide to go home and follow the plan of care prescribed by their physicians as best they can within the limitations of their abilities. Sometimes their conditions improve, and they can stay at home as they did before they became ill. Other times their conditions worsen enough to meet the criteria for hospitalization.

The cost of their care is then higher and the length of their hospitalization is longer because of the increased severity of their illness. A flexible wage criteria and deletion of the required 3-day acute care state prior to skill care admission would allow for the patient, patient's family, and the physician to select the most appropriate level of care. Consideration could then be given to the type of social, financial, and medical aspects of the patient's care; focussing beyond the patient's immediate medical needs would encourage health maintenance prevention and potentially lower the cost overall.

Another example of this system's fragmentation occurs at the time of a patient's discharge from the acute sitting. The patient's condition is stable, and his care can be provided in a nonacute setting; however, the patient may not physically be ready to go home. For example, in 4 to 5 days after a patient has surgery for a fractured hip and the postoperative course proceeds without complication, his condition is considered stable. At this point the patient primarily needs physical therapy for day training and would meet the criteria for skilled care and not acute care.

Several outlying facilities are only able to provide physical therapists 2 days a week and physical therapy by a technical aid the remaining 3 days; whereas, Medicare criteria requires physical therapy be provided by a physical therapist 5 days a week for reimbursement at the skill level. The patient's care is adequate but not covered by Medicare.

Due to these Medicare restrictions, patients from outlying areas are often required to continue their physical therapy in Scottsbluff. Coverage issues such as this limit the patient's right of choice.

The patients often come to the hospital with the idea they will stay in the hospital until they are completely well and able to return home. In today's system it no longer works this way. The process of utilizing the levels of care within our system does not meet the patient's or his family's expectation of health care. It is often confusing and stressful to them, especially when the patient qualifies only for the intermediate level of care, because the intermediate level of care is not covered by Medicare reimbursement.

We have had several families take a patient home and make the best of a bad situation. The patient and/or his family did not have the funds to pay for continued care and did not qualify for Medicaid assistance and/or were unable to accept admission to a nursing home as a level of care.

Within our system it would be helpful if there was reimbursement at an intermediate level for short-term recuperation in lieu of hospitalization or post hospitalization as rest for families and situations where the limitations of resources preclude any other options.

Often private insurers, through their case management programs, allow for this type of flexibility. At this time we do not have the ability to be flexible within Medicare or Medicaid programs.

The recent processes for Medicare and Medicaid problems are cumbersome and time consuming. In the time I have been a utilization review specialist all of the preprocedure reviews we are required to perform with the Peer Review Organization have been approved, yet we must continue to perform these reviews to receive payment for the procedures.

It would seem more reasonable to review the problem areas and not continue to review areas of compliance. Assistance in the interpretation of the guidelines on a concurrent basis would be beneficial. For example, a patient who exceeds the physical intermediary outpatient criteria, but fails to meet the Peer Review Organization's acute care criteria, leaves the hospital and physician at risk for quality of concern and/or financial denial. This creates a dilemma of how and where to provide care for the patient.

A definitive decision by the Peer Review Organization as to the appropriate determination of the level of care is not readily available on a concurrent basis. This creates confusion for the patient and family, physician, and hospital. A flexible range of criteria would be helpful to give to the patient's physician and would provide some options rather than constraints.

In conclusion we need to build flexibility into the health care system to meet the problems of limited resources in rural areas, fragmentation of care, and the social issues of fragile elderly living alone. This can be done by increasing our focus on preventive and maintenance care, development of care management approach, and revision of criteria. Medicare needs to educate the public in regard to the levels of care our system currently requires us to utilize, and the constraints health care providers must operate within, that is, the issuance of denial letters, Medicare, Medicaid criteria. The education and written material from Medicare and Medicaid must use language in terms the general public can understand.

Last, we need to streamline the review process focussing on problem areas and not areas of compliance. Thank you.

PREPARED STATEMENT

Senator **KERREY**. Thank you very much, Ellen. We have your prepared statement and it will be made part of the record.

[The statement follows:]

STATEMENT OF ELLEN PUTNAM

ADMISSION

Over the past few years, hospitals, physicians, and patients have had to contend with an ever changing health care system. These changes have included an increase in the complexity of the system, a criteria base for the various levels of care, a limited supply of resources in rural areas, and a limited understanding by the public attempting to use the system. These in turn have lead to a fragmentation of health care, a loss of patient rights of choice and a loss of the personal human touch.

We often see elderly people, who marginally manage at home. When they become ill they seek medical attention from their family physician or in an Emergency Room. They may not be ill enough to meet the criteria for hospitalization yet may be too ill to care for themselves alone at home. The dilemma then exists of where and how to provide care. The severity of their illness and the intensity of the service they require, does not necessarily match the admission criteria for acute care. They have not met the 3 day acute care requirement for Medicare to reimburse at the skilled level. Their level of care may meet the intermediate criteria but that level of care will not meet the needs of an incubating illness. They also may not have the financial resources to pay for the intermediate nursing home care.

Medicare does not cover intermediate care and patients view nursing home care as the last stop before death. They prefer staying in their own home, but resources within the family may be very limited to provide physical assistance. Home health and homemaker services are available in some areas but not in others.

Patients may decide to go home and follow the plan of care prescribed by their physicians as best they can within the limitations of their abilities. Sometimes their conditions improve and they can stay at home as they did before they became ill. Other times their conditions worsen enough to meet the criteria for hospitalization. The cost of their care is then higher and the length of their hospitalization is longer because of the increased severity of their illness. A flexible range of criteria and deletion of the required 3 day acute care stay prior to skilled care admission would allow for the patient, patient's family and the physician to select the most appropriate level of care. Consideration could then be given to the psychosocial, financial and medical aspects of the patient's care. Focusing beyond the patient's immediate medical needs would encourage health maintenance, prevention and potentially lower the cost overall.

DISCHARGE

Another example of the system's fragmentation occurs at the time of a patient's discharge from the acute setting. The patient's condition is stable and his care can be provided in a non-acute setting, however, the patient may not be physically ready to go home. For example, within 4 to 5 days after a patient has surgery for a fractured hip and the post-operative course proceeds without complication, his condition is considered stable. At this point the patient primarily needs physical therapy for gait training, and would meet the criteria for skilled care and not acute care. Several outlying facilities are only able to provide a physical therapist 2 days a week, and physical therapy by a technical aide the remaining 3 days, whereas Medicare criteria requires physical therapy be provided by a physical therapist 5 days a week for reimbursement at the skilled level. The patient's care is adequate, but not covered by Medicare. Due to these Medicare restrictions, patients from outlying areas are often required to continue their physical therapy in Scottsbluff. Coverage issues such as this limit the patient's right of choice.

The patients often come to the hospital with the idea they will stay in the hospital until they are completely "well" and able to return home. In today's system it no longer works this way. The process of utilizing the levels of care within our system does not meet the patient or his family's expectations of health care. It is often confusing and stressful to them. Especially when the patient qualifies only for the intermediate level of care. Because intermediate level of care is not covered by Medicare reimbursement, we have had several families take a patient home and make the best of a bad situation. The patient and/or his family did not have the funds to pay for continued care, did not qualify for Medicaid assistance and/or were unable to accept admission to a nursing home as a level of care within our system.

It would be helpful if there was reimbursement at an intermediate level for short term recuperation in lieu of hospitalization, post hospitalization, as respite for families, and in situations where the limitation of resources precludes any other options. Often private insurers through their case management programs allow for this type of flexibility. At this time, we do not have the ability to be flexible within the Medicare/Medicaid programs.

REVIEW PROCESS

The review process for the Medicare and Medicaid programs are cumbersome and time consuming. In the time that I have been Utilization Review Specialist all of the pre-procedure reviews we are required to perform with the Peer Review Organization have been approved. Yet we must continue to perform these reviews to receive payment for the procedures. It would seem more reasonable to review problem areas and not continue to review areas of compliance.

Assistance in the interpretation of the guidelines on a concurrent basis would be beneficial. For example a patient who exceeds the fiscal intermediary's outpatient criteria, but fails to meet the Peer Review Organization's acute care criteria, leaves the hospital and physician at risk for a quality concern and/or financial denial. This creates a dilemma of how and where to provide care for the patient. A definitive decision by the Peer Review Organization as to the appropriate determination of the level of care, is not readily available on a concurrent basis. This creates confusion for the patient and family, physician and hospital. A flexible range of criteria would be helpful and give the patient's physicians and provider some options, rather than constraints.

In conclusion, we need to build flexibility into the health care system to meet the problems of limited resources in rural areas, fragmentation of care and the social issues of the fragile elderly living alone. This can be done by increasing our focus on preventative and maintenance care, development of a case management approach and revision of the criteria. Medicare needs to educate the public in regards to the levels of care our system currently requires us to utilize, and the constraints health care providers must operate within—that is, issuance of denial letters, Medicare/Medicaid criteria. The education and written material from Medicare/Medicaid must use language and terms the general public can understand. Lastly, we need to streamline the review processes, focusing on problem areas and not areas of compliance.

NEW CARE MEDICAL EQUIPMENT CO.

STATEMENT OF MARK SELVEY

Senator **KERREY**. The next witness is Mark Selvey, New Care Medical Equipment Co. here in Scottsbluff.

Mr. **SELVEY**. Mark Selvey, 1614 6th Avenue, Scottsbluff.

I have been in health care delivery for about 20 years having worked in and around hospitals since graduating from high school. My first job was that of a janitor in Clarkson Hospital in Omaha, NE. Since then I have worked as a physical therapy aid, staff respiratory therapist, director of respiratory therapy, a hospital vice president. Currently I own and operate a medical equipment company.

My experience gives me a unique perspective on health care, much of that experience coming in the rural setting. In the process I have learned a little bit about business, a little bit about health care delivery, and really I do not see much distinction between the two.

The first thing I know is everyone in the country wants to be as healthy as they can be. When they are faced with a health problem in their lives—either their own or that of a loved one—they want the very best care that money can buy. No one in this country is willing to settle for less. This is not necessarily good or bad; it is just a fact.

The problem is that the best is expensive. Quality and prices are unquestionably tied. In a free market you cannot have one without the other. So the dilemma faced by every consumer is this, How much quality can I afford?

The second thing I have learned is that business is not all that complicated. It basically boils down to a simple relationship between the seller and buyer. It is just a matter of lining up the incentives so that each party walks away from the transaction with their needs met. The seller's job is to find out what the customer wants or needs and provide that product. The customer's job is to make informed buying decisions and pay for the product. Everything else is just cosmetic.

The problems with health care is it is a little more complicated than that. To start with, it is not easy to determine just who the buyer is, because the buyer and the payer are rarely the same person. In health care the patient is the recipient of the product, but he or she may not have control over the buying decision. The patient may want one thing or one level of care, but the payer may not be willing to pay for that. This leaves the provider of the services with two choices: Provide the highest quality of care to all patients, and shift costs to the better payers, or provide different levels of care based on the patient's ability to pay.

Currently we see the former, but a time is coming when payers are going to refuse to bear any more than just the cost of care provided to their insured. That will pose an interesting problem. What level of care do we as a society want to accept as the minimum level available to all of our citizens?

Typically, the argument is this: Do we allow everyone to participate in all aspects of the health care system without regard to their ability to pay, or do we let the forces of the free market determine who will get what level of care? I think that argument is a waste of time, because let's face it, Americans are never going to settle for anything less than the very best medical care our doctors and researchers can dream up, and we are never going to settle for less than one level of care for all our citizens.

The idea of rationing health care is totally foreign to us, and we will not stand for it. The real problem is how we are going to assure that every citizen, wealthy or indigent, urban or rural, has reasonable access to that care, and believe me I think we are sorely mistaken if we look to either industry or government alone to solve that problem.

In my mind health care delivery in this country is first and foremost a business. It happens to employ a great number of people who care very little about financial statements and bottom lines, and thank God for those people. But ultimately any individual, partnership, corporation, or other entity that participates in any commercial activity must be one of two things: subsidized or profitable.

Now, either of these can work, but each have drawbacks. Subsidies can allow the system to operate and have the added perk of giving tremendous control to the subsidizing party. Standards of quality, productivity, and pricing can all be regulated as part of the agreement. The obvious drawback is that this will be extraordinarily expensive for the party doing the subsidizing and the taxpayer. Additionally, State and Federal governments have not proven to be particularly effective when it comes to overseeing industry in this fashion.

Profits, on the other hand, also allow the care to be delivered by giving the providers an incentive to stay in business and require a truly free market and informed consumers. Profit driven companies also require every customer to pay for the goods that he or she consumes, leaving us with this nasty business of what to do with those folks who cannot afford care as well as a possibility of price fixing, gouging, collusion or any one of 100 sins committed by business.

I have to say here that I do not have the single sweeping and elegant solution to the problem, but I have some idea what one would look like. I also have some idea of what it should not look like. The solution is not another Government run national insurance program like Medicare. In fact, I would propose that poor old Medicare be allowed to die a dignified death, and that we bury the old girl.

It is the best argument I know for keeping the Government out of the insurance business. Medicare is ill conceived, poorly administered, and forces the Government to be constantly at odds with health care providers. We are continually trying to figure out ways to squeeze more money out of the system. HCFA is continually trying to invent new ways to cut costs. It is a game where they invent the rules, and we try to find clever ways around them.

The problem is that politics get in the way of policy, and the result is a patchwork system that does not work for the payer, provider or the beneficiary. The solution is also not complete privatization. I know enough about business to know that the poor and the rural areas will get left out in the cold if we do not give insurance companies and providers some incentive to take care of them. Without those incentives providers will concentrate on the areas with large populations, particularly those with relatively high and median incomes, and the inner cities and rural areas will be chronically underserved.

The solution that I think is most plausible is to move the Government slowly but surely out of the insurance business. I think it is time for the Government to sit with industry leaders representing physicians, hospitals, care facilities, suppliers, and the insurance companies and forge an alliance that will line the incentives up correctly.

Let the private sector take care of those who can afford it, either on their own or through their employer, and let the Government buy insurance for the folks who fall through the cracks. The actuaries can sharpen their pencils, and the insurance companies can set their rates, so they make a fair rate of return on every policy. Hospitals and other providers can do the same. Then make some sort of accretion inventory and let the accretion folks set the quality standards. In a few years you will have providers competing on quality with the best facilities advertising their quality ratings. So what have we gained? Well, under such a system:

One: The market determines prices as insurance companies balance the cost of a covered service against the risk of losing insurance to competitors.

Two: The providers maintain minimum levels of quality set by accretion bodies such as JCHO and offer less profitable care at their own risk.

Three: The taxpayers get what they need in the form of quantified risk.

It will be much easier to plan if you do not have to guess the number of gallbladder operations you will have to pay for in a year. An additional advantage would be the deduction administration cost with the dismantlement of HCFA.

Four: And finally, the patient gets what we all want, and that is equal access to the best medical system available in the world.

My suggestion can be stated very simply. Let us quit working against each other. Let us sit together, the health care industry and Government, and chart a course that meets all of our needs and provides access to care.

PREPARED STATEMENT

Senator KERREY. Thank you very much, Mark. That was a 2-hour lecture in a 7-minute period. We have your prepared statement and it will be inserted in the record.

Mr. SELVEY. I wanted to get it all in.

[The statement follows:]

STATEMENT OF MARK SELVEY

I have been in health care delivery for about 20 years, having worked in and around hospitals since graduating from high school. My first job was that of a janitor at Clarkson Hospital in Omaha, Nebraska. Since than I have worked as a physical therapy aide, staff respiratory therapist, director of respiratory therapy, and hospital vice-president. Currently I own and operate a medical equipment company. My experience gives me a unique perspective on health care, with much of that experience coming in the rural setting. In the process I have learned a little bit about health care delivery, and a little bit about business, and really, I don't see much distinction between the two.

The first thing I know is that everyone in this country wants to be as healthy as they can be, and when they are faced with a health problem in their lives, either their own or that of a loved one, they want the very best care that money can buy. No one in this country is willing to settle for less. This is not necessarily good or bad, it's just a fact. The problem is that the best is expensive. Quality and price are unquestionably tied. In a free market, you can't have one without the other. So, the dilemma faced by every consumer is this, "How much quality can I afford?"

The second thing I have learned is that business is not all that complicated. It basically boils down to a simple relationship between the seller and the buyer. It is just a matter of lining up the incentives so that each party walks away from the transaction with their needs met. The seller's job is to find out what the customer wants or needs and provide that product. The customer's job is to make an informed buying decision, and pay for the product. Everything else is just cosmetics.

The problem with health care is that it's a little more complicated than that. To start with, it's not always easy to determine just who the buyer is because the buyer and the payer are rarely the same person. In health care, the patient is the recipient of the product, but he or she may not have control over the buying decision. Many times, that is left to the insurance company. The patient may want one thing, or one level of care, but the payer may not be willing to pay for that. This leaves the provider of the services with two choices: provide the highest quality care to all patients and shift costs to the better payers, or provide different levels of care, based on the patient's ability to pay. Currently, we see the former, but a time is coming when payers are going to refuse to bear any more than just the cost of care provided to their insured. And that will pose an interesting problem: "What level of care do we, as a society, want to accept as the minimum level available to all of our citizens?" Typically, the argument is this: "Do we allow everyone to participate in all aspects of the health care system, without regard to their ability to pay, or do we let the forces of a free market determine who will get what level of care?"

I think that argument is a waste of time. Because, let's face it, Americans are NEVER going to settle for anything less than the very best medical care our doctors and researchers can dream up. AND, we are never going to settle for anything less than one level of care for all of our citizens. The idea of rationing health care is totally foreign to us, and we won't stand for it. No, the real problem is how we are going to assure that every citizen, wealthy or indigent, urban or rural, has reasonable access to that care. And believe me, I think we are sorely mistaken if we look to either industry or government to solve that problem alone.

In my mind, health care delivery in this country is first and foremost a business. It happens to employ a great number of people who care very little about financial statements and bottom lines, and thank God for those people, but ultimately any individual, partnership, corporation, or other entity that participates in any commercial activity must be one of two things: subsidized or profitable. Now either of these can work, but each have drawbacks.

Subsidies can allow the system to operate, and have the added perk of giving tremendous control to the subsidizing party. Standards of quality, productivity, and pricing can all be regulated as a part of the agreement. The obvious drawback is that this would be extraordinarily expensive for the party doing the subsidizing, the taxpayer. Additionally, State and Federal governments have not proven to be particularly effective when it comes to overseeing industry in this fashion.

Profits, on the other hand, also allow the care to be delivered, by giving the providers an incentive to stay in business, but require a truly free-market and informed consumers. Profit-driven companies also require every customer to pay for the goods he or she consumes, leaving us with this nasty business of what to do with those folks who can't afford care, as well as the possibility of price-fixing, gouging, collusion, or any one of a hundred sins committed by business.

I have to say here that I don't have the single sweeping and elegant solution to this problem. But I have some idea of what one would look like. I also have some idea what it should NOT look like.

The solution is NOT another government-run national insurance program like Medicare. In fact, I would propose that poor old Medicare be allowed to die a dignified death and that we bury the old girl. It is the best argument I know for keeping the government out of the insurance business, Medicare is ill-conceived, poorly administered, and forces the government to be constantly at odds with the health care providers. We're continually trying to figure ways to squeeze more money out of the system, and HCFA is continually trying to invent new ways to cut costs. It's a game where they invent new rules, and we try to find clever ways around them. The problem is that politics gets in the way of policy, and the result is a patchwork system that doesn't work for the payer, provider, OR the beneficiary.

The solution is also NOT complete privatization. I know enough about business to know that the poor and the rural areas will get left out in the cold if we don't give the insurance companies and providers some incentive to take care of them. Without those incentives, providers will concentrate in the areas with large populations, particularly those with relatively high median incomes, and the inner cities and rural areas will be chronically underserved.

The solution that I think is most plausible is to move the government slowly, but surely, out of the insurance business. I think it is time for government to sit with industry leaders representing physicians, hospitals, care facilities, suppliers, and the insurance companies and forge an alliance that will get the incentives lined up correctly. Let the private sector take care of those that can afford it, either on their own or through their employer, and let the government BUY insurance for the folks who fall through the cracks. The actuaries can sharpen their pencils, and insurance companies can set their rates so that they make a fair rate of return on every policy. Hospitals and other providers do the same. Then make some sort of accreditation mandatory, and let the accreditation folks set the quality standards. In a few years, you will have providers COMPETING on quality, with the best facilities advertising their quality ratings.

So what have we gained. Well, under such a system:

1. The market determines prices as insurance companies balance the cost of a covered service against the risk of losing insureds to competitors.
2. The providers maintain minimum levels of quality set by accreditation bodies such as JCAHO, and offer less profitable care at their own risk.
3. The taxpayers get what they need in the form of quantified risk. It will be much easier to plan when you don't have to guess the number of gall bladder operations you will have to pay for in a year. An additional advantage would be the reduction in administrative costs as we dismantle HCFA.
4. And finally, the patient gets what we all want, equal access to the best medical system available in the world.

So my suggestion can be stated very simply: let's quit working against each other; let's sit together, the health care industry and government, and chart a course that meets all of our needs and provides access to health care for everyone.

Thank you.

Box Butte General Hospital

STATEMENT OF BILL FERGUSON, ADMINISTRATOR

Senator **Kerrey**. The next witness is Bill Ferguson who is the administer of Box Butte County Hospital in Alliance.

Mr. **Ferguson**. Bill Ferguson, 2111 Edith Court, Alliance, NE.

Thank you for the opportunity to make this presentation. The current condition of rural health care as noted is on the brink of disaster with mounting regulations, reduction in medical payment, discrimination in wage raises from urban to rural hospitals and from State to State, increased paper work, and failure to coordinate health policy with other agencies. Current regulations for Medicare patients with both policy and reimbursement are approximately 18 inches deep, front and back of each page, with new changes seeming to be coming out daily and designed for 200-or-more-bed hospitals with little care as to the cost of those regulations.

An example would be that if a patient is admitted by an emergency room physician and must have a surgery and a prosthetic device and an EKG, five forms for payment must be submitted for that one patient. Approximately $2 million is spent in Nebraska alone to check the utilization of Medicare patients by the peer review organization which could go toward the patient care.

Urban, regional, referral centers, and rural hospitals are paid an alarming difference of 35 percent from urban down to rural hospitals. No more than 100 miles from Alliance, NE, Wyoming hospitals receive approximately 20 percent more in wage reimbursement. The Federal Government has given grants to come up with new ways to refer to rural health care, but ultimately IRS rules and Medicare fraud and abuse laws have tied our hands with respect to joint venturing anything with physicians or other hospitals.

Most hospitals cannot keep up with the mounting paperwork jungle which is not being reimbursed. Our clerical staff has increased by almost 40 percent since 1982 which does not leave much for bedside nursing. The ample nursing staff is moving away due to our inability to pay the wages they can receive in the urban area. Personnel is almost nonexistent unless they are married or moving to town.

Since 1982 the writeoffs to Medicare for our hospital have increased by 318 percent. Physicians are not being reimbursed adequately for their care of Medicare patients. I have heard that surgeons in Denver, CO, receive as much as 70 percent more for the exact same surgery in Alliance, NE, and also the office calls are being paid at least 50 percent above our rural physicians.

I doubt the costs of living in those areas are that much higher. It is no wonder why it is difficult to recruit physicians to rural areas to work harder, being on call probably tenfold more, and receiving far less money for the same service. Many physicians are not taking Medicare and Medicaid patients due to the lack of payment, and the numbers are growing. What do we do then?

Medicare disallows any costs by hospitals to recruit physicians to see Medicare patients, so, therefore, this cost must be shifted to patients to pay for the services as well as for the low-cost services provided by hospitals. Who tells the 89-year-old person to drive 60 to 80 miles for emergency care when no physicians will see Medicare patients, or they have all moved to better reimbursable areas.

Hospitals and physicians play an enormous role in the economy and economic development in rural areas which could be lost. This would be devastating to this country. The first and fastest approach is to put a moratorium on all Medicare cuts even if it means putting a surtax on Social Security until a national health policy concerning Medicare and Medicaid can be developed. During this time period, instead of reducing hospital payments, the Health

Care Financing Administration should be forced to compare its percentage of administrative costs per health dollars spent with that of the commercial health insurance industry.

Then solutions could be drawn from that about contracting on the regional basis or set administrative goals for HCFA. The ultimate national health policy must decide on the provision of all services to Medicare patients or on basic services that are at least paid out at no less than cost.

Additionally, those options could be chosen at an early age when Social Security is started. That payment should be separated from the retirement part of Social Security into its own medical payment funds and increased at no less than the overall CPI increase each year. It should be guaranteed to a person at retirement age.

The rural health future is in danger but can be salvaged with national health reform. Reform, if approached properly, will also assist urban hospitals in their struggle with increasing charges to cover Medicare's lack of payment.

The 1990, 11.6-percent reduction in Medicare payment to rural hospitals will be devastating since many rural Nebraska hospitals have spent their reserves to continue operations for their patients and have been financially responsible. It is time to stop and take a close look at the system itself. There is a need to simplify this system and decide our future direction with a panel of commercial insurance carriers, Medicare officials, Senators, congressional representatives, and most of all rural urban health representatives and their public.

Their tasks should be to arrive at a suggested national health policy for consideration within a reasonable amount of time such as 6 months—somewhat like a Presidential national health policy. Thank you

PREPARED STATEMENT

Senator KERREY. Thank you, Bill, very much. We have your prepared statement and it will be inserted in the record.

[The statement follows:]

STATEMENT OF BILL FERGUSON

The current condition of rural health care as I currently know it is on the brink of disaster with mounting regulation, reduction in medical payment, discrimination in wage rates from urban to rural hospitals and from State to State, increased paperwork and failure to coordinate health policy with other agencies. The current regulations for Medicare patients for both policy and reimbursement are approximately 18 inches deep, front and back of each page, with new changes seeming to be coming out daily and designed for 200 or more bed hospitals with little care to the cost of those regulations. An example would be that if a patient is admitted by our emergency room physician and must have surgery and a prosthetic device and an EKG, five (5) forms for payment must be submitted. Approximately $2 million is spent in Nebraska alone to check utilization of Medicare patients by the Provider Review Organization which could go toward patient care. Urban, Regional Referral Centers and Rural Hospitals are paid at an alarming difference of 35 percent from urbans down to the rural hospitals. No more than 100 miles from Alliance, Nebraska, Wyoming hospitals receive approximately 20 percent more in wage reimbursement. The Federal Government has given grants to come up with new ways to approach rural health care, but alternately IRS rules and Medicare Fraud and Abuse laws have tied our hands with Joint Venturing anything with physicians. Most hospitals cannot keep up with the mounting paperwork jungle which is not being reimbursed. Our clerical staff has increased by almost 40 percent since 1982 which doesn't leave much for bedside nursing. Ample nursing staff is moving away due to our inability to pay the wages of the urban areas. Recruiting personnel is almost non-existent unless they are married or moving to town. Since 1982, the write-offs to Medicare for our hospital have increased by 318 percent.

Physicians are not being reimbursed adequately for their care of Medicare patients. I have heard that surgeons in Denver, Colorado, receive as much as 70 percent more for the exact same surgery in Alliance, Nebraska, and also office calls are being paid at least 50 percent above our rural physicians. I doubt the cost of living in those areas are that much higher. Is it no wonder why it is difficult to recruit physicians to rural areas to work harder, be on-call probably tenfold and receive far less money for the same services. Many physicians are not taking Medicare and Medicaid patients due to the lack of payment and the numbers are growing. What do we do then? Medicare disallows any costs by hospitals to recruit physicians to see Medicare patients; so, therefore, this cost must be shifted to patients who pay for their services as well as the below cost services provided by hospitals. Who tells the 89-year-old person to drive 60 to 80 miles for emergency care when no physicians will see Medicare patients or they have all moved to better reimbursed areas?

Hospitals and physicians play an enormous role in the economy and economic development in rural areas which could be lost and be devastating to this country. The first and fastest approach is to put a moratorium on all Medicare cuts even if it means putting a sur-tax on Social Security until a National Health Policy concerning Medicare and Medicaid can be developed. During this time period, instead of reducing hospital payments, the Health Care Financing Administration should be forced to compare its percentage of administrative costs per health dollar spent with that of the commercial health insurance industry. Then, solutions could be drawn from that about contracting on a regional basis or set administrative goals for HCFA. The ultimate National Health Policy must decide on the provision of all services to Medicare patients or basic services that are at least paid at no less than cost without the rules and regulations defining that a telephone, television, physician recruitment, and the other stacks of regulations are not a cost to Medicare patients. Medicare options at higher costs or commercial extended policies could be added at extra cost to the subscriber. Additionally, those options could be chosen at an early age when Social Security is started and that payment should be separated from the retirement Social Security into its own Medicare Payment Fund and increased at no less than the overall CPI increase each year and guaranteed to a person at retirement age.

The rural health future is in danger, but can be salvaged with national health reform. The reform, if approached properly, will also assist urban hospitals in their struggle with increasing charges to cover Medicare's lack of payment. The 1990 11.6 percent reduction in Medicare payment to rural Nebraska hospitals will be devastating since many rural Nebraska hospitals have spent their reserves to continue operations for their patients and have been fiscally responsible.

It is time to stop and take a close look at the system itself. There is a need to simplify the system and decide our future direction with a panel of commercial insurance carriers, Medicare officials, Senators and Congressional Representatives, and most of all rural and urban health representatives. Their task should be to arrive at a suggested National Health Policy for consideration within a reasonable amount of time (such as six months), somewhat like a "Presidential National Health Policy Commission."

OGALLALA COMMUNITY HOSPITAL

STATEMENT OF LINDA NEESE, ADMINISTRATOR

Senator **KERREY**. The next witness is Linda Neese the administrator of the Ogallala Community Hospital in Ogallala, NE.

Ms. **NEESE**. 300 East 10th Street, Ogallala, NE.

For rural health care to have a future, we have to address the issue of access as several other people have said. I believe those of us who live in rural areas should have access to quality medical care just the same as those who live in urban areas. We must have adequate physicians and other health professionals in the rural areas.

To attract more physicians we need to expand our scholarship programs. I do not think low-interest loans are going to do it. We need to recruit from the rural areas such as the new Chadron and University program does, and also something has to be done about the Medicare reimbursement for physicians.

Right now a physician practicing in rural Nebraska pays a significant penalty and, because of that, gets a much lower Medicare reimbursement. Now, we do offer a great lifestyle out here, but it is pretty hard to persuade a young doctor to come out and work for more hours for less money. This also affects our ability to retain physicians.

I think that better linkages such as computer hookups, with urban medical centers would also help this problem.

My second area of concern is the Medicare reimbursement problem. In our rural hospitals we are still getting less than the urban facilities for providing the same care. Congress tried to correct that by increasing our inpatient reimbursement; however, they also changed the case mix index on the DRG's most commonly treated in our rural hospitals, and that cost our hospital $14,000 last year or a 2-percent reduction on Medicare reimbursement.

The outpatient reimbursement was also reduced, so between the two of those, that pretty well wiped out that inpatient reimbursement that everyone thought they gave us. Therefore, this is an area that must be equalized in order for rural hospitals to stay in business. I do not believe that this would be that expensive.

We make up a small percent of the total Medicare dollars, but we always seem to be hit pretty hard by some of the changes. For example, because of the new wage index adjustment, Nebraska hospitals are projected to lose $11.7 million in 1991 and $15.5 million in 1992. This comes at a very bad time when we are experiencing cost increases in wages and supplies. When you put all this together, Medicare makes it pretty hard for rural hospitals to stay open.

The third area that is a problem for rural hospitals is the medically indigent patients. Most of these people think of this as an urban problem, but 30 percent of the uninsured people in this country live in rural areas, so this is our problem too. Right now if you are employed at a low-paying job, your employer does not provide insurance. You probably cannot afford to pay your medical bills. The paying customers, whether private or third party, make up this difference.

Therefore, I believe we probably will see some kind of national health insurance, a sort of basic plan that would give everybody access to preventive measures, prenatal care, and certain acute procedures. I think that is fine as long as we are very, very careful how we structure it.

First of all, it would have to be adequately funded which Medicare never has been. It should also only cover basic services. If patients want more than that, they can pay or buy insurance coverage to pay. This would assure basic health care access for all, and that would help the rural facilities as well as the urban facilities.

Please understand that we are not asking for some kind of special subsidy in rural health. We are asking for a level playing field. We want to be treated the same as our urban counterparts. We do not get any breaks when our tax money goes the other way. So we feel that when services are coming this way, we should be treated the same also. Thanks.

Senator **Kerrey**. Thank you, Linda. For your information, there is a piece of legislation that we hope will take care of part of that. Senator Packwood actually consolidated an effort that was made last year in the budget reconciliation method. Both Senator Daschle and myself support that, and it will eliminate the differential in reimbursal.

I think it is a very important thing to do. It also incorporates an additional bill that Senator Daschle introduced that is called the Rural Nursing Incentive Act. It requires reimbursement for Medicare for nurse practitioners which I also think is a big assistance in rural health.

As you point out, it will have significant rural support. By rural support we are talking about Senator Packwood, Senator Bentsen, Senator Dole. We are talking heavy guys in the U.S. Senate. That would revitalize the national health service core. It does provide scholarships for so-called underserved areas in almost the entire state of Nebraska.

There is, I think, awareness of the sorts of the things you are talking about. I hope they will be addressed yet in this session of the Congress.

PREPARED STATEMENT

Thank you again, Linda. We have your prepared statement and it will be inserted in the record.

[The statement follows:]

Statement of Linda Neese

For Rural Health Care to have a future, we must address the issue of access! I believe those of us who live in rural areas should have access to quality medical care just the same as those who live in urban areas. We must have adequate physicians and other health professionals in the rural areas. To attract more physicians, we need to expand some of our scholarship programs. I think we need to recruit from the rural areas as the new Chadron and University Program does and also that something is going to have to be done about the Medicare reimbursement for physicians.

Right now, a physician practicing in rural Nebraska pays a significant penalty because of that. They get a much lower Medicare reimbursement. We do offer a great life style here but it's pretty hard to persuade a young doctor to come out and work more hours for less money. This also affects our ability to retain physicians. Better linkages such as more computer hook ups with the urban Medical Centers would also help.

The second area of concern is the Medicare Reimbursement problem in our rural hospitals. We are still getting less than the urban facilities for providing the same care. Congress tried to correct that by increasing our inpatient reimbursement. However, they also changed the case mix index on those DRG's most commonly treated in rural hospitals and that move cost our hospital $14,000.00 or a 2 percent reduction on our Medicare reimbursement. The outpatient reimbursement was also reduced so that pretty well wiped out our increase in inpatient reimbursement. Therefore, this is an area that must be equalized in order for rural hospitals to stay in business. I don't believe that this would be expensive. After all, we make up a very small percentage of the total Medicare dollars, but we seem to be being hit pretty hard by some of the changes. For example, because of the new wage index adjustment, Nebraska hospitals are projected to lose $11.7 million in 1991 and $15.5 million in 1992. This really comes at a bad time when we are experiencing cost increases in wages and supplies. So, when you put all this together, Medicare does make it very difficult for the rural hospitals to remain open.

The third area that is a problem for rural hospitals is the medically indigent patients. Most people think of this as an urban problem, but 30 percent of the uninsured people in this country live in the rural areas, so it is our problem. Right now, if you are employed at a low paying job and your employer does not provide insurance, you probably cannot afford to pay your medical bills. The paying customers whether private or third party pick up this difference. I believe that we will see some kind of national health insurance, a sort of basic plan that would give everybody access to preventive measures, prenatal care and to certain acute procedures. I think that is fine as long as we are very careful about how we structure it. It would have to be adequately funded, which Medicare never has been. It should also only cover the basic services. If patients wanted more than that, they would pay or buy insurance coverage to pay. This would assure basic health care for all. It would help the rural facilities as well as the urban facilities. Please understand that we are not asking for some kind of special subsidy in rural health. We are asking for a level playing field. We want to be treated the same as our urban counter parts. We don't get any breaks when our tax money is going the other way, so we feel that when the services are coming this way we should be treated the same also.

PANHANDLE MENTAL HEALTH CENTER

STATEMENT OF AL ROEHL, CLINICAL PSYCHOLOGIST

Senator **KERREY**. The next witness is Al Roehl of the Panhandle Mental Health Clinic.

Mr. **ROEHL**. I am Al Roehl, 4110 Avenue D, Scottsbluff, NE.

I have been working in mental health programs in Nebraska as a clinical psychologist. I have consulted with the staff of mental health centers, had their input into a long laundry list of needs and things that have to be done for mental health in this rural area. That is contained in the written testimony, and you can look at that.

It includes such things as respite and support care for the mentally ill in the community when longer hospitalization is not needed, and a need for more satellite services, so services can be closer to home. I am left with three major conclusions.

One is that rural mental health services are now heavily subsidized, and they will need to continue to be. These problems are longstanding, often deep-seated. It takes a certain kind of outside support to do what needs to be done.

But, second, there is a realistic limitation on the amount of money that can be put into these things, and I do not see that it is going to be increased very much. In fact, I am very skeptical about the value or need for increased funding by starting a lot of new programs anyway, because these things traditionally have a life of their own. They keep building and the turf situations are set up. You never eliminate a program once it gets going. So I look for things which can be done very economically and yet very effectively to improve the quality of life and to alleviate mental health problems, and, as I will mention later on, perhaps some physical problems as well.

There is this great concern over lack of services and difficulty in getting quality physical care to everybody, but economic and cheap programs can be done, and they can be done very well. Things like education, training, and effectiveness have a large impact in this rural area. There are many families who are multigenerationally involved in the family farm or in a small business, and there are a number of stresses. There is a lot of value with that. There is cooperation and a unity, but often there are tensions as the succeeding generations come along and wonder how to divvy up the power and resources.

Education can be very helpful, but I think the main point I would like to make today is that some type of systematic reorganization, redefinition, realignment of forces with what is existing now can pretty much take care of that problem. I have got a couple really good examples.

In the Panhandle of Nebraska, for the first time in Nebraska, there was started a program called critical incident stress debriefing. This is a great example of cooperation across agencies between communities, no turf battles at all, and it is extremely effective.

What happens out here is that emergency responders, ambulance personnel, police, and others are called right away to these tragic accidents that happen on the farm or on the interstate, and the people that they are picking up in a bloody condition often are friends and neighbors or are related to people. They know this takes a tremendous toll psychologically on their mental health, and there has been an awful lot of turnover, because these people burn out. They do not need that kind of stress.

This program gets a team together, debriefs the responders in a group in a very informal type of setting and alleviates much of their mental anguish and keeps them on the job. They get back into the frontline very quickly, and it is very cost effective, just a little bit of umbrella money involved, and most of it is volunteer work.

Another example of redefinition has carried us a long way. In the old days we used to think mental illness was a criminal problem or perhaps diabolic possession of something awful. It was then redefined as illness, and that had other implications of hospitalization, asylum treatment, taking care of a person.

Now, we are getting into definitions of let the person be responsible for their own recovery, and self-health groups of which there are many. There is a program here in Scottsbluff called Cirrus House where people with very severe problems are encouraged with mutual support and some staff support to see as their goal full employment. The aim is not only to get them off the program and become taxpayers, but to give them that satisfaction of accomplishing something and achieving mental health.

A growing edge, I think, is in the area of health psychology—helping people go to physicians' offices because of emotional and social problems. I see an increasing liaison in that area. Senator Daschle and Senator Kerrey, thank you very much for coming to see us today.

PREPARED STATEMENT

Senator KERREY. Thank you very much, Al. Your prepared statement will be inserted in the record.

[The statement follows:]

STATEMENT OF AL ROEHL

I am Al Roehl, a clinical psychologist who has spent over thirty years in rural Nebraska working in programs to help foster mental health, for seven years at a state hospital for the mentally ill and for over twenty years in a community mental health center. I am indebted to my coworkers for providing much of the background and material for these comments, and I am indebted to my work setting, the Panhandle Mental Health Center, for providing the milieu for developing these ideas.

The comments are ultimately my own, however, and not the official position of any agency or group of people. If there is anything of value, it does come from the excitement and caring atmosphere surrounding my work in Nebraska.

Some of the needs specific to the rural groups served by the Panhandle Mental Health Center which have been identified by the clinical staff are the following: a residential treatment center for youth, respite care for families providing the majority of services to a mentally ill family member, services available closer to small rural communities—satellite outpatient programs, funding for medications when the family cannot afford to maintain a person on expensive drugs, programs for recruiting and training and retaining professional staff, programs for the rural elderly, programs for those suffering from both mental illness and mental retardation, especially youngsters with mental retardation who at times get out of control, frequent classes and training experiences in parenting skills, stress management, coping with teen-agers, marital adjustment. Special problems for this area come from the greater distances which must be traveled to reach services. These problems of distance compound the relative lack of resources.

I will discuss three principles: (1) Rural mental health care is now highly subsidized and the need for support will continue. (2) There are not now and will not be in the foreseeable future enough resources to meet all of the identified needs for services to the mentally ill. (3) We can get along well with the resources available now while improving mental health care through gentle nudges and changes of attitude, which will be discussed later.

Because most problems of emotional and mental adjustment are deep seated and take a relatively long time to change, the cost of treatment can be expensive in the long haul. Therefore it is apparent that some form of assistance or support will be necessary for most people, whether this help comes from various levels of government, from some type of insurance payments, from private philanthropy or volunteers. A question to be addressed is, "What type of system can best apportion the resources to the areas of need?"

In identifying the areas where new and expanded services should be set up, the first approach seems always to be to provide funding for more staff to deliver more services along with building or remodeling more buildings in which to deliver the services.

I do not believe this is the answer. More buildings, more staff, and more funding may be a boon for some of the problems, at the Mental Health Center where I work there are now over 30 people on a waiting list for routine services, and it will be a long time before they can be worked into the routine schedule, but it is obvious that existing funding sources will not simply pump more and more money into care for the problems of mental illness in the rural areas. We should not ask for more buildings and more staff and more money. We should look for ways to coordinate and utilized more effectively the resources now available, to apply the technology already developed, to continue the present mechanisms of research and program evaluation so that knowledge can be applied quickly and effectively.

Rural people share many of the problems of living with their urban brothers and sisters, problems of family break-up, underemployment, substance abuse. Yet rural communities have the advantage of the healthy harmony of an individualism and self-sufficiency on the one hand balanced with a neighborly attitude of help and concern on the other hand.

What can be done to improve rural mental health care without a major infusion of resources? I will mention three broad areas: (1) an emphasis on education, which will serve both to improve the quality of life and also to prevent the occurrence of more serious problems; (2) treatments which are focused and targeted to specific difficulties; (3) systematic use of a variety of strategies which are less costly and more effective.

(1) Self-help classes in parenting skills and marital adjustment in rural areas can and are tailored to special concerns for families facing stresses fluctuating farm economics, ranch and farm families tied together in a family business with two or three generations both enjoying and suffering from the intertwining of kinship and livelihood. The value of other educational programs is well recognized, and this value would obtain in rural areas as well.

(2) Focused and targeted interventions, treatments, are generally more inexpensive and quicker than long-term involvement with a therapist. Both have their place, but with limited resources the emphasis, ceteris paribus, must be on short-term treatment. Treating a farmer, for example, of a phobia for bees and flying insects can quickly get him back in the fields working without anxiety or fear. In other words, everybody does not need psychoanalysis.

(3) The value of a systems approach has long been recognized. Many factors, often relating to "turf" issues, make this difficult to accomplish. I would like to mention a few examples of successful "gentle nudges" toward more effective rural mental health programs which somehow are able to flourish, with only minimal funding or with much less funding than alternatives.

A program which for Nebraska was started here in the panhandle is a good example of inter-agency cooperation, effective use of volunteers, and the delivery of impressive benefits. This is the program of having debriefing meetings with persons who respond to emergency situations in order to defuse the ill effects of being involved in a stressful predicament. The program is called Critical Incident Stress Debriefing. Persons involved might be ambulance personnel, firemen, police officers. In rural areas the emergency personnel responding to an emergency, perhaps a vehicle or farm accident, will frequently be acquainted with the victim and their family. This can place a burden of stress which in the past resulted in emotional and family problems and a high turnover in personnel in such occupations because of burn out. This program, utilizing existing resources, quickly and effectively provides excellent benefits.

Sometimes dramatic results come from relatively simple changes. There is the long-ago story of the physician who put an end to a local epidemic by taking the handle off of the town pump with the contaminated water source. We now realize that problems formerly called mental "illness" or "nervous breakdown" can be redefined as problems of adjustment and living or, better yet, opportunities for learning and growth; the emphasis then shifts from the need for care in a hospital or asylum toward improving adjustment in the community. Today in Scottsbluff, Nebraska, there exists a club house for persons, many of whom would have been considered seriously mentally ill and hospitalized in a state institution. The members of this club house, Cirrus House, see their mission as providing mutual support and encouragement to achieve the main goal of the club house, to become gainfully employed. There is an economic benefit from the less costly program to provide an umbrella for this club house and from returning many to the role of tax-paying wage earner. Perhaps the biggest benefit is the shift in emphasis which allows people to enjoy the satisfaction of moving toward more independence.

I will mention only in passing, since their merit is well known, self-help programs such as Alcoholics Anonymous and Recovery, Inc. These depend largely on volunteer time and energy, cost very little in public funds, and in many cases are the most effective programs available.

My penultimate note is a call to explore and develop similar programs in other areas. The area of health psychology would be one starting place. Since many of the persons seeking care in a physician's office are there primarily because of emotional and mental problems, there will be increasing cooperation between medical practitioners and those who are trained in helping people deal with problems of living from a psychological and social perspective. Because of shortages of medical care in rural areas, there may be an opportunity for rural America to be on the forefront of the development of this alliance. Many "illnesses" are identified as having, at times, primarily psychological causes: ulcers, some headaches, even allergies and asthma. Pain itself, aside from having the value of signaling us to take care of something or avoid the burning fire, can have a large subjective component. Psychological intervention alone can alleviate much felt pain, with an enhancement in quality of life and productivity. The use of psychology and counseling techniques to help educate and motivate people toward more healthy life styles, including good diet, exercise, social interactions, would do much to decrease the need for medical care as well as improving the commonweal.

What is needed now for rural mental health programs is a vision of a coordinated system of existing resources to alleviate the suffering of mental and emotional stress and to improve the quality of adjustment as a benefit in itself and as a defense against future problems of mental and social imbalance.

STATEMENT OF DR. C.J. CORNELIUS, JR.

Senator **Kerrey**. The next witness from Sidney, NE, Dr. C.J. Cornelius.

Dr. **Cornelius**. Thank you, Senator. It is nice to see you again. I am C.J. Cornelius from Sidney.

First let me thank you for the opportunity to appear before you today as a representative of my profession as a primary care physician with over 36 years of practice in western Nebraska. I must hasten to add the future of health care in rural Nebraska has never been in jeopardy as it is today.

The reason for that status is Government. Since the passage of Medicare in 1965, the great overpromise of my lifetime, Government is providing now virtually one-half of the reimbursement for medical services and over 90 percent of the regulation.

When Medicare was passed there was a provision in the original bill that stated that Government would not interfere with the physician-patient relationship. That provision was abandoned during the 1980's, and the preparation of regulations and the tone of letters written to beneficiaries interfere with that relationship daily.

The activities of the PRO interfered daily with the physician-patient relationship and are retrospectively threatening denial of reimbursement to hospitals and physicians for services already provided. A physician reviewer, who by statute has to remain nameless, has reviewed the patient's hospital charts and said he would have cared for the patient differently and that his way would have been better. This is particularly ominous for rural physicians whose percentage of record reviews is significantly higher than his urban counterpart, and who did not have a category specialist they can call upon to share the responsibility of a patient's care, or have the sophisticated diagnostic equipment the urban doctor has at his disposal to assist him in difficult diagnostic problems.

Because it is easier for Government and its agents, the fiscal intermediaries, to computerize their claims, processing physicians are now required to reduce every medical diagnosis and every patient's service to a numerical code before submitting it for payment, or it will not be accepted. This is required for physicians and hospitals to employ additional staff and computers in order to keep up with complexities in this situation.

Many of the Medicare recipients have 10, 12, or 15 diagnoses, and in addition to listing them you must prioritize them, so the fiscal intermediaries may subject them to computer screenings which are programmed to check for appropriateness of services rendered. The fiscal intermediary is under the direction of HCFA and are also denying payment or down coding the level of services or requesting additional documentation for the care of hospitalized patients who remain in the hospital longer than 10 days in 1988, longer than 7 days in 1989, and in 1990 over 6 days.

The provisions of this documentation cost more in time and effort than the reduced payment offered by the fiscal intermediary. I call this process Governmental stealing, and it is a deplorable practice, because the physician has no opportunity to discuss the complexities of a given case with a physician who might understand the situation. No explanations are provided if the additional documentation is not accepted. Government further added to the cost of the claims processing for physicians by the Medicare amendments of 1989.

Because of the complexities of filing Medicare forms, numerous organizations sprang up over the country to assist senior citizens in filing claims and ensuring reimbursements for services. The amendments provided for an alleged increase in reimbursement for rural physicians, but this was offset by a 2.096-percent Gramm-Rudman reduction for services from October through March 1990 and a 1.4-percent Gramm-Rudman reduction for services after April 1.

However, when the other shoe dropped, physicians were also required to file all claims for Medicare patients at no cost starting September 1, 1990. These changes virtually canceled any increase in reimbursement. The infamous max, the maximum allowed of actual charges of Government's price fixing for physicians services, were imposed in 1987. These charges carried with them the threat of legal action on the part of Government if you charged more than the fixed amount even though Government reimbursement remained unchanged.

As a result a physician can be fined $2,000 per incident, and that may be $5,000 since the amendments of 1989 are eliminated from the Medicare program because billing is in error.

In the last 6 months, I received three different sets of max charges from the fiscal intermediary. I wanted to show to you that it is 188 pages of computerized numbers only, and also a 6-page document how to interpret the document, and then also telling me what would happen if any the charges were not used in the updated version.

The most recent and unbelievable fiasco being foisted on physicians and their patients which will impact rural physicians more than anyone is clear, is the Clinical Laboratory Act of 1988. This legislation grew out of the operation of some pap smear factories which apparently provided substandard pap smear reviews; however, the result is total overkill for laboratory services. These regulations promised to deny rural patients the benefit of offsite testing in their physician's office; such mundane testing as blood count, urine analysis, or blood cholesterol unless he has his laboratory licensed appropriately and takes part in a proficiency testing program which will cost $750 to $1,000 a year, and a licensing fee of $2,000 that had been proposed by the Secretary of HHS.

The Secretary also has recommended only three levels of laboratories. There should be 10 or 12 at least, and the level should take into consideration the sophistication of the equipment onsite rather than group, for the ease of the regulators, from the laundry list as it is now.

What compounds this law is that it applies to laboratory services provided for all patients, not just Medicare and Medicaid. As a result, patients have to travel to another site, and in rural areas to another city, to obtain laboratory services. Physicians' offices are not selling laboratory services to other physicians but are doing laboratory services for the benefit and convenience of their own patients and should be permitted to continue to do so without Government regulations.

The assumption of Congress and of the public in general is that there will always be bright young students waiting in line to go to medical school and continue to provide high-quality care to all. I am here to tell you that unless the regulatory climate changes drastically in the next few years this will not be so. There were medical schools that did not have enough qualified applicants to fill their freshman class this last year, and the University of Nebraska admitted 14 out of every 15 applicants. This contrasts to 15 to 20 applicants for every position from the freshman class going into medical school. This makes the picture for the rural physician replacement quite dismal. Many rural physicians are on call 24 hours a day and many times 7 days a week.

In addition to being on call for my patients at all hours, I have taken my turn at the hospital emergency room for patients without a local physician every sixth or seventh week for the past 34 years. Urban physicians have no such patient or emergency room responsibilities. Younger physicians are taught in medical school to guard their time more zealously, and most are not willing to take on time commitments.

Essentially, the practice will be overregulated and underreimbursed; Federal regulation is killing the profession that I love, and I must say to you that if I was a student today deciding on a career, I would not choose medicine. Why? Because the overregulation and interference of the Government has taken the excitement and the fun out of my medical practice, and I resent the attitude of the regulators that all physicians are crooks and have to be watched like a hawk.

Nearly all the physicians that I know, and I know hundreds of physicians, are honorable, hardworking, conscientious practitioners and put their patients' welfare above their own. Please do not think that people in rural America deserve no more than the barefoot doctor like in China. Rural Americans have lost their train service, most of their bus service, much of their airline service. Do not let rural Nebraskans or rural South Dakotans become second-class citizens when it comes to health care. Thank you very much.

PREPARED STATEMENT

Senator **KERREY**. Thank you very much. Your prepared statement will be inserted in the record.

[The statement follows:]

STATEMENT OF C.J. CORNELIUS, JR., M.D.

First let me thank you for the opportunity to appear before you today as a representative of my profession and as a rural primary care physician with over 36 years of practice in Western Nebraska. I must hasten to add that the Future of Health Care in rural Nebraska has never been in jeopardy as it is today and the reason for that status is Government. Since the passage of Medicare in 1965—the great overpromise of my lifetime—Government is providing virtually half of the reimbursement for medical services and over 90 percent of the regulation. When Medicare was passed, there was a provision which stated that Government would not interfere with the Physician-Patient Relationship. That provision was abandoned during the 1980's and the proliferation of regulations and the tone of the letters written to beneficiaries interfere daily with that relationship. Examples of that interference is the favored status of the physicians who take assignment under Medicare and the correspondence sent to Medicare beneficiaries stating that if they would desert their personal physician if he doesn't take assignment they will have to pay less for their service. What those letters fail to say is that if they lived in almost any other State in the USA their physician's services would qualify for a higher reimbursement even though their Medicare Premium would remain the same.

The activities of the PRO interfere daily with the Physician-Patient Relationship by retrospectively threatening denial of reimbursement to hospitals and physicians for services already provided, because a physician's reviewer, who by statute shall remain nameless, has reviewed the patient's hospital chart and decided that he would have cared for the patient differently and his way would have been better. This is particularly onerous for rural physicians whose percentage of records reviewed is significantly higher than his urban counterpart and who do not have a cadre of specialists that they can call upon to share the responsibility of a patient's care or have the sophisticated diagnostic equipment that the urban physician has at his disposal to assist him in difficult diagnostic situations. The rural primary care physician may have to provide pediatric, obstetric, orthopedic, urologic, cardiologic, emergency medicine and even psychiatric care in many situations and he is reimbursed at primary care rates only and frequently has to defend his care in order to get paid at all.

Because it is easier for Government and its agents, the Fiscal Intermediaries, to computerize their claims processing, physicians are now required to reduce every medical diagnosis and every patient service provided to a numerical code before submitting a claim or it will not be accepted for payment. This has required physicians and hospitals to employ additional staff and computers in order to keep up with the complexities of this situation. Many of the Medicare recipients have 10, 12, or 15 diagnoses and in addition to listing them, they must also be prioritized so the Fiscal Intermediaries may subject them to computer screens which are programmed to check for appropriateness of services rendered. The Fiscal Intermediaries, at direction of HCFA, are also denying payment, down-coding the level of services or are requesting additional documentation for the care of patients hospitalized longer than 10 days in 1988, 7 days in 1989, and 6 days in 1990. The provision of this documentation many times costs more in time and effort than the reduced payment offered by the Fiscal Intermediary. I call this process "Governmental stealing" and it is a deplorable practice because the physician has no opportunity to discuss the complexities of a given case with a physician who might understand the situation. No explanations are provided if the additional documentation is not accepted.

Government further added to the cost of claims processing for physicians by the Medicare Amendments of 1989. Because of the complexity of filing Medicare forms, numerous organizations sprang up all over the country to assist senior citizens in filing claims and in assuring reimbursement for services. The Amendments provided for an alleged increase in reimbursement for physicians, especially rural physicians, but this was offset by a 2.09 percent Gramm-Rudman reduction for services from October 1989 through March 1990 and a 1.4 percent Gramm-Rudman reduction for services after April 1, 1990. However, when the other shoe dropped, physicians were required to file all claims for Medicare patients at no cost starting September 1, 1990. These changes virtually canceled any increase in reimbursement for physicians.

The infamous MAAC's (Maximum Allowable Actual Charges), Government's way of price fixing for physicians services, were imposed in 1987. These charge ceilings carried with them the threat of legal action on the part of Government if you charged more than the fixed charge, even though Government reimbursement remained unchanged. As a result a physician can be fined $2,000 per incident (it may be $5,000 since the amendments of 1989) or eliminated from the Medicare Program if his billing is in error. In the last 6 months, I have received 3 different sets of MAAC charges from the Fiscal Intermediary, 188 pages each, and an accompanying letter admonishing me to be sure to follow the latest set or I am in violation of the Federal rules.

The most recent and unbelievable fiasco being foisted on physicians, which will impact rural physicians and their patients more than any other, is CLIA, the Clinical Laboratory Improvement Act of 1988. This legislation grew out of the operation of some Pap Smear Factories which apparently provided substandard quality Pap Smear reviews. However, the result is total "overkill" for laboratory services from those as simple as dipstick urine test for determining the PH or the presence of Glucose to the most sophisticated determination of trace elements or immune substances in blood or spinal fluid. These regulations promise to deny rural patients the benefit of onsite testing in their physician's office of such mundane testing as a blood count, a urinalysis, or blood cholesterol, unless he has his lab licensed appropriately and takes part in a proficiency testing program that will cost from $750 to $1,000 per year. A licensing fee of $2,000 has been proposed by the Secretary of HHS. Of the thousands of tests available of varying complexity, the Secretary of HHS has recommended only 3 levels of laboratories. There should be 10 or 12 levels at least and the levels should take into consideration the sophistication of the equipment onsite rather than grouped for the ease of the regulations from a laundry list, as is now proposed. In our office we purchased a computerized laboratory machine which requires very little personnel expertise but under the current proposals we can't use this machine's capability because some of the tests it can do are in the level II and in order to use it for these tests, we would have to employ a pathologist and a full time laboratory technician, if you could hire them, in order to do so. The operation of this equipment is so simple that any intelligent high school student can be taught to use it proficiently. What compounds this law is that it applies to laboratory services provided to all patients, not just Medicare and Medicaid, and will result in patients having to travel to another site and in some areas to another city to receive laboratory services because the regulations are so onerous, the cost is so high to qualify, and Medicare reimbursement will, if you haven't already guessed, not increase to cover the additional cost. Physician's offices are not selling laboratory services to other physicians but are doing laboratory services for the benefit and convenience of their own patients only, and should be permitted to continue to do so without government regulation.

The assumption of the Congress and of the Public in general is that there will always be bright students waiting in line to go to Medical School and continue to provide high quality care to all. I'm here to tell you that unless the regulatory climate changes drastically in the next few years this will not be so. There were medical schools that did not have enough qualified applicants to fill their freshman classes this past year and the University of Nebraska admitted 14 out of every 15 applicants. This contrasts with 15–20 applicants for every position in the freshman class when I went to medical school. This makes the picture for rural physician replacement quite dismal. Many rural physicians are on call 24 hours a day and many times 7 days a week. In addition to being on call for my patients at all hours, I have taken my turn as the hospital emergency physician for patients without a local physician every 6th or 7th week for the past 34 years. Urban physicians have no such patient or emergency room responsibilities. Younger physicians are taught in medical school to guard their time off zealously and most are not willing to take on such time commitments especially when their practice will be over-regulated and under-reimbursed.

Federal Regulation is killing the profession I love and I must say to you that if I were a student today deciding on a career, I would not choose medicine. Why? Because the over-regulation and interference of Government has taken the excitement and the fun out of my medical practice and I resent the attitude of the regulators that all physicians are crooks and have to be watched like a hawk. Nearly all the Physicians I know, and I know hundreds of physicians, are honorable, hard working, conscientious practitioners of the healing art and put their patients' welfare above their own day in and day out. My plea to you is that Government should recognize that Medical Practice in a rural setting is more difficult and more demanding than that of Urban Practice (I have done both) and should be recognized as such by all payers. Don't think for one minute that people in Rural America deserve no more than "barefoot doctors," like in rural China, in the form of Nurse Practitioners or Physician Assistants. Rural Americans have lost their train services, most of their bus services, and much of their airline services. Don't let Rural Nebraskans or Rural South Dakotans become second class citizens when it comes to health care.

Deregulate the practice of medicine so that it becomes attractive again as a profession for bright young students. Free enterprise continues to be the cornerstone of our society and should continue in health care as well. The mistake of Medicare was providing subsidized care for all senior citizens, not just those in need. One Britisher remarked years ago that their National Health Service taught them that "you can't tax the people enough to give them something for nothing."

In the time allotted, I was not able to mention the problem of professional liability, the product liability of physicians. This problem has been out of hand for the past 15–20 years. What other segment of our society can expect to be sued successfully, not just for Mal-practice but for a poor result. Our current Tort System has become a reparations system, an award to persons without good outcomes from "rich" insurance companies. Although I believe in trial by a jury of one's peers, I do not believe that the average lay juror is in any way a physician's peer in professional liability cases. The tragedy of the current system is that more than 75 percent of the money expended in these cases goes to lawyers, not to the person who is the victim of true Malpractice or one who just has a bad outcome. I continue to feel that a system similar to that of the Workman's Compensation Court would work well in this area and would save countless millions of dollars in health care cost. One reason that I discontinued Obstetrics in my Medical practice was the threat, both real and theoretical, of obstetrical patients presenting at the emergency room when I was the emergency physician with a complicated pregnancy which resulted in a poor outcome. Our society is riddled with persons looking for that "pot of gold," a successful malpractice suit, which would permit them to retire for the rest of their lives.

I would like to include with my presentation a copy of an analogy written by the CEO of a hospital in Waco, Texas which presents the plight of hospitals under Medicare Regulations, a scenario not unlike that of physicians in over-regulation. This analogy would be humorous except that it is painfully true.

I have spent more than 20 years in Health Planning at the State level, having been appointed by Senator Kerrey, then the Governor of Nebraska, to the Statewide Coordinating Council for Health Planning under P.L. 93-641. It was obvious at the outset that many persons are ready and willing to make decisions regarding health care before they understand the problems. Most of the time I spent in providing education to those members of the planning body with no medical background. When they understood the problem, they made good decisions but when they brought to the meetings their biases only and refused to consider the facts, their decisions were deplorable. The advisers to Congressmen and Senators on health matters frequently have limited experience in the field and have equally limited perspectives. Several years ago a survey of the advisers on health matters was carried out and the average length of involvement in health matters by the health advisers was 1.5 years. I would hope that each of you would have some practitioners in your home States whose judgment you value that you might call upon when matters of health are being debated.

The role of Government in health care ought to be limited to the determination of what level of health services should be provided to all citizens (a basic health care package) and then to subsidize the care of those unable to pay for such health insurance. The private health insurance industry is far better equipped to provide this basic health care package than is government and then can make available supplemental health insurance policies for those who choose to spend their resources for additional coverage rather than spend it for other things.

An additional role for Government may well be in determining whether persons who practice unhealthy life styles should receive their basic coverage at the same rate as those who practice healthy life styles. It has been estimated by very knowledgeable persons that 50 percent of the cost of health care in this country results from smoking and the use of alcohol. Should these persons pay a higher premium than those who do not smoke or drink? If health care is a right, is not the avoidance of unhealthy life styles a responsibility?

There is one last item I must mention. Proposals for relicensure, retesting, and recredentialling of physicians are constantly being proposed in legislative bodies. It has always been difficult for me to understand why these proposals are so attractive to legislators who qualify for their positions by age, citizenship, and residency in their district and by being elected but do not have to qualify by testing of any kind and are not subject to retesting to determine if their skills and knowledge qualify them to run for reelection. In order to practice my profession I first had to be graduated from an accredited School of Medicine, pass a licensure examination, take intern and residency post graduate training, and then be tested in the market place daily. In addition I must continue to qualify as a member of my specialty, the Academy of Family Physicians, by taking 150 hours of continuing medical education every three years. Additional State or Federal testing just adds to my "time away from practice" cost and serves no useful purpose. I don't mean to be flippant in this regard but it behooves legislators to put themselves in the shoes of the "regulated" so to speak before deciding to vote in favor of additional regulation for any segment of society. I wonder if Congressman Ron Widen would have proposed CLIA 88 if he had done so?

[From the NHA Monitor, May 21, 1990]

HEALTHCARE & A BAG OF GROCERIES

Charles J. Dougherty, Ph.D., director of Creighton University's Center for Health Policy and Ethics has sent the following article by Kent Keahev, CEO, Providence Health Center, Waco, TX which is reprinted with the author's permission:

"Consider, if you will, what it would be like if grocery stores were paid for the goods they supplied in the same manner as today's hospitals are reimbursed for the services which they provide.

Imagine what it would be like to operate a grocery store where approximately 50 percent of your groceries were purchased by one buyer (Medicare) who pays for the groceries its clients (Medicare beneficiaries) consume; sets a fixed price per bag of groceries regardless of the contents of the bag (DRG payments); stipulates what must be put in the bag (through peer review, regulation, or litigation) and has made it illegal for you to bill anything more than a small portion of the actual bill (copayments and deductibles) to the person who actually receives the groceries (patient) or the person's representative (supplemental insurance carrier) regardless of the cost of the items in the bag.

Imagine that an additional 5 percent of your groceries' are purchased by another buyer (Medicaid) for its clients who operates by essentially the same rules but is much more stingy in the price it will pay per bag (State Medicaid DRG payments).*

Imagine further that you are required by law, or the needs within your community, to provide approximately another 5 percent of your groceries to people unable to pay for them. Many of these people present themselves at your door (Emergency Room) hungry and malnourished. Others apply for free food you are legally obligated to provide to a prescribed amount due to obligations you incurred in obtaining funds to build your store (Hill-Burton obligations). Still others in your community need food which, because of your mission, you seek to provide to the extent of your abilities because you care (charity care).

On top of this, imagine that roughly another 10 percent of your groceries are bought by people who promise to pay you, and could, but don't (bad debts).

Finally, consider that the remaining 30 percent of the groceries on your shelves are sold to individuals who have arranged for someone else (an insurance company) to pay for all or part of their bill. To your subsequent surprise, that payor then refuses to honor this obligation either by delaying payment pending "review" (cash flow tactics), or denying payment because the grocery purchase was not "authorized" in advance (pre-certification), wasn't found to be "necessary" (utilization review) or was not the kind of food they had agreed to pay for (coverage exclusions). When you fail to collect from this source, you then discover, to your further surprise, that some of those individuals who have already consumed the groceries no longer feel any personal obligation for the bill and obviously cannot return the groceries for credit.

Sound far fetched? Well, this is the exact situation confronting our nation's hospitals today. Is it any wonder that many have closed and others will soon follow?

Fortunately, in a grocery store you can still go in and, with complete freedom of choice, fill your basket with lobster, filet mignon, Wheaties, apple pie, or whatever your heart desires knowing that ultimately there will be a reconciliation at the check-out counter where you will pay the price for each item selected (fee for service). If you are wondering why the small country grocery stores are fading from the scene (rural hospitals), ask yourself how long any grocery store, even the one down the street from you, would be able to stay open if it were paid in this manner. Is it any wonder there is a growing crisis in healthcare in this country?"

*Note.—The analogy regarding State Medicaid DRG payments applies to Texas.

STATEMENT OF DR. VINCE BJORLING

Senator **Kerrey**. The next witness is Dr. Bjorling from Scottsbluff Internal Medicine.

Dr. **Bjorling**. Vince Bjorling, 3301 Newbell Court, Scottsbluff.

I want to take this opportunity to thank Senator Kerrey and Senator Daschle for coming to Scottsbluff and hearing about the rural health care problem, and I think its very commendable what you guys have done over the last several days of traveling to different communities in Nebraska and South Dakota.

I agree with everybody who has come to the podium before me when they tell you that they feel that rural health care is in a crisis situation, and I certainly feel that way at this point in time, and I feel that probably here in western Nebraska we are the first area in the country to experience the real brunt of the crisis.

My biggest interest in rural health care problems at this point in time has clearly been the recruiting and retention of physicians. As I watched things occur over the last 4 years since I finished my residency and came out to western Nebraska, I have seen many physicians retire as they were approaching the retirement age, and it seemed like a greater proportion of physicians in western Nebraska were approaching that age, and we lack the ability to recruit any young physicians to replace them. I think that this is always going to be a problem to recruit people to rural areas, but it is even more of a problem now, and I think the Government has played some role in that. We have talked about the problems, and you have heard them all today in terms of recruiting and retention in terms of Federal mandates and regulations and the reimbursement issue, and I think those are all very, very important. I just want to briefly go through some of the things that I had come up with in terms of solutions.

I think in the panhandle we have a lot of work to do to provide physicians with things that will improve their practices and quality of life, such as quick access to consultations and approved call coverage accessibility to continued education, assisting with quality control and peer review and taking innovative approaches to helping physicians in very small practices deal with the hassles posed by Medicare and third-party carriers.

In addition to the things that we need to do, the Government can help us out most in terms of the following things. The first thing would be to change the physician reimbursement and significantly decrease or eliminate the discrepancies between urban and rural physician reimbursement.

This has to be done in order to have a chance to recruit and retain physicians in rural areas. There is an incredible demand for primary care physicians throughout the country in a limited and dwindling supply.

We are working on the things that I have mentioned, but unless there are some changes in the reimbursement, I do not feel that we will be competitive or successful at recruiting physicians to rural areas.

No. 2, we need to improve the reimbursement for our rural hospitals. They too are dealing with probably higher cost when compared to urban hospitals, because they have to buy in smaller volumes and deal with professional help that is much more expensive, and it is very important that they have adequate reimbursements, so they can remain competitive to recruit and retain allied health personnel such as nurses, technicians, therapists, et cetera.

Physicians alone cannot provide quality care, and it takes allied health personnel as well to carry this out.

The third thing I think we have to look very closely at is all the Government mandates and regulations that are enacted, particularly with a focus on what effects they may have on rural health care. We deal with physicians who have limited access to a technology when they are in small communities that are very isolated.

And the last thing we need is to have the Government stepping in and taking away what little technology from them, because they cannot comply because it is too expensive or whatever.

The final thing we need to do is come up with a national plan to deal with the increasing shortage of primary care physicians. Unfortunately the changes in medicine over the last 6 years have discouraged many potential applicants from applying to medical school. This is very unfortunate. If this trend continues there will not be the same quality of people entering medical school that there once were. In addition, the number of people entering primary care has dramatically decreased over the last 6 or 7 years.

This is reflected in the recent polls and surveys which show that 40 percent of physicians if given the opportunity to make their career choice again would opt out of medicine. I suspect that the majority of these are people who presently are in primary care, and their dissatisfaction stems directly from the Government involvement which is discriminatory against them with respect to reimbursement and Federal regulations.

We must come up with some plan that will continue to encourage highly motivated, capable, dedicated individuals to choose medicine as a career and particularly primary care specialties.

And I thank you again.

PREPARED STATEMENT

Senator **Kerrey**. Thank you, doctor. We have your prepared statement and it will be inserted in the record.

[The statement follows:]

Statement of Vincent G. Bjorling, M.D.

Senators Kerrey and Daschle: I want to thank you for coming to Scottsbluff today to receive testimony concerning the future of rural health care. I feel that this is rapidly becoming one of the greatest problems facing rural America and this problem must be dealt with quickly and effectively if rural health care is to survive. Health care in rural settings must survive to serve our farmers, ranchers, and the people who live in smaller communities and serve the ranchers and farmers. To have reasonable access to health care is imperative to maintain a decent quality of life. If we are unsuccessful in supplying reasonable access to health care, productivity will be greatly reduced and many communities that provide vital services to rural residents will cease to exist. This would he a tragedy and I feel that it does not have to happen.

Last fall a task force met in North Platte to address the rural Nebraska health care needs. In reviewing the current physician man power supply and demand, several points became obvious:

(1) There are several areas throughout the state, particularly in the western half, where there is an unmet demand for primary care physicians. This includes family practitioners, internists, pediatricians, surgeons, and psychiatrists. The problem is expected to reach the acute stages in the western part of the state initially and then will spread to the northern part, then central, and finally southern part of the state. We have begun to see this. From 1986 to 1989 the number of primary care physicians in the Panhandle of Nebraska excluding Scottsbluff County, fell from the number of forty-two physicians to thirty-two physicians. Unfortunately the number has decreased by another five or six physicians this spring.

(2) The average age of rural physicians suggests that many of the physicians in rural Nebraska are rapidly approaching retirement age.

(3) The number of young physicians to be trained in primary care specialties around the country and those with an interest in rural medicine continues to decline.

We recognize that there are many things which are unattractive about practicing medicine in a rural setting, particularly small practices. Typically the physicians have to contend with an increased number of hours of work which usually translates to much less time spent with their families. In addition, they often spend more time on call and often have feelings of isolation and lack of having adequate back up. This leads to increased responsibility and liability and they are also faced with practicing medicine with less technology available to them than their urban counterparts. Rural physicians are also faced with lower reimbursement for the services provided when compared to their urban counterparts. This is a very important issue, particularly when you consider young physicians. Eighty-one percent of all physicians graduating from medical school have debt. The average debt is $42,000 as the cost of medical education has greatly risen over the last ten years. It is clear that many medical students graduate with debt much greater than $42,000. It is not uncommon to find students who owe anywhere from $70,000 to $100,000. It is clearly difficult to attract physicians with large sums of debt or any sums of debt when they are going to be discriminated against with respect to reimbursement.

At the same time there are many advantages to practicing in a rural setting. Physicians can experience increased autonomy along with the opportunity to play a larger role for the good the of the community than their urban counterparts. In addition, the life-style of smaller communities can be very appealing to certain individuals who want to raise their families in smaller, healthier, cleaner communities.

There is also a great deal to be said for caring for rural patients as opposed to urban patients. I think most of us who practice in a rural setting would not trade our patients for anyone else's as we feel that these are some of the finest people in the world to care for.

The problems with recruiting and retaining physicians in rural areas has been a major problem for a long time. This problem has become significantly worse over the last several years and has now reached a very critical level. When I arrived in Scottsbluff four years ago, I sat down and looked at the age of the physicians in the surrounding communities and could see that over the next ten years there would be a significant shortage of physicians in western Nebraska. We felt recruiting by these communities and for them would be very difficult. We underestimated how difficult it would be though. Then another thing happened that we did not anticipate. Scottsbluff has also had trouble recruiting and retaining physicians. In the last four years we have lost ten primary care physicians and have only been able to replace one. We now have a significant primary care physician shortage as well.

The government has played a major role in our present problems. The government has set up many different locales in the United States with different reimbursement schedules. Rural Nebraska is ranked at the very bottom in terms of Medicare reimbursement.

It is very unfortunate that Medicare reimbursement was set up in the manner in which it was: Those physicians who practiced in rural areas traditionally had lower fees as they lived in smaller communities and strived very hard to give their patients a very good value for their medical dollars. However, they did have the option of increasing their fees until 1984. Since the freeze of fees in 1984, rural physicians have been maintained at the lower reimbursement rates and punished for being economical and efficient in the past. This has caused many physicians to move their practices to urban areas and has caused many patients to seek their care in urban areas. Essentially these same services are being provided but at a much higher cost to the government. The fees should not be based on where one lives. They should be based on the services rendered. Board certified primary care physicians in western Nebraska should receive the same compensation as do board certified primary care physicians in urban areas. When you have people with similar qualifications providing the same services, they should get the same reimbursement.

The premise is wrong that it is cheaper to provide care in a rural practice than in an urban practice. In fact, it is usually more expensive when one considers that supplies are often more expensive and professional services are more expensive when they are purchased in smaller quantities.

The government has willfully and knowingly discriminated against rural physicians and has also discriminated against rural patients. This happens when considering accepting assignment. Urban physicians are much more likely to accept assignment (that is when they receive 80 percent of what Medicare has allowed and 20 percent is paid by the patient out of pocket). Rural physicians' maximum allowable charges and total fees are often much less than the 80 percent amount that Medicare reimburses the urban physicians. Therefore rural doctors are less able to accept assignment and the patients must pay more money out of their pocket than if they had seen an urban physician. Not only does money flow from rural areas to urban areas to subsidize health care but our patients pay more out of pocket expenses for their health care as well. Rural patients pay the same tax rate that urban patients pay. This is very unfair and must change.

Some people think that the physicians simply want more income. I think that this is not the case, the physicians in western Nebraska are some of the finest trained, conscientious, hard-working, and dedicated physicians in the country. As I talk to most of the physicians who remain in the region, they seem to be fairly happy with their incomes. They usually have to work fifteen to twenty hours a week more than their urban counterparts to make a comparable amount of income. This significantly effects the rural physicians' quality of life as they are less able to spend time with their families, etc. These things aside, I feel that what upsets everyone the most, is what effects the reimbursement issue has on recruitment and on retention of physicians. Over the last year we have practiced in an underserved area with respect to physicians. I, and all the physicians in the Panhandle, can tell you how stressful this is and how it rapidly leads to dissatisfaction with one's practice. It is very discouraging as well to know that your chances of recruiting new physicians and replacing retiring physicians is very poor. This is why the reimbursement issue is so important.

We have a lot of work to do in the Panhandle to provide physicians with the things that will improve their practices and quality of life, such as quick access to consultations, improved call coverage, accessibility to continuing education, assisting with quality control and peer review, and taking innovative approaches to deal with hassles posed to physicians by Medicare and third party carriers.

In addition to the things that we will need to do, I feel that there are four ways in which the government can help us with rural medicine:

(1) Change physician reimbursement and significantly decrease or eliminate the discrepancies between the urban and rural physician reimbursement. This has to be done if we are to have a chance to recruit and retain physicians in rural areas. There is an incredible demand for primary care physicians throughout the country and a limited and dwindling supply. We are working on the things that I have mentioned above to provide a better quality of life and better practice opportunities for rural physicians, but unless the reimbursement changes are made we won't be able to compete with urban areas when it comes to recruiting and retaining physicians.

(2) Reimbursement for rural hospitals should not be significantly less than that for urban hospitals. Again, they are often dealing with higher costs in the delivery of their care than urban hospitals. It is important that rural hospitals also be competitive and able to recruit and retain allied health personnel, such as nurses, technicians, therapists, and etc., so that quality care can be delivered. Physicians alone cannot deliver health care that is needed.

(3) All health care legislation and government mandates must be carefully scrutinized and the implications they may have on small rural practices must be considered before these policies are enacted. Many of today's pending mandates require that the same standards or controls be met in small rural practices as are required in large urban corporate practices. This is impractical. You can't have the same standard of care in a community of one thousand people that you have in a community of a million people as much as we would like that. Instead a situation is created where further restrictions are placed on the physician and further technology may be stripped away from the physician and make their job tougher, if not impossible. We need to carefully look at health care legislation and federal mandates and how they impact rural medicine.

(4) Come up with a national plan to deal with the increasing shortage of primary care physicians. Unfortunately the changes in medicine over the last six years have discouraged many potential applicants from applying to medical school. This is very unfortunate. If this trend continues there will not be the same quality of people entering medical school that there once was. In addition, the number of people entering primary care has dramatically decreased over the last six or seven years. I feel that this is reflected by the recent polls and surveys we have seen which shows that forty percent of today's physicians if faced with an opportunity to make their career choice again would opt out of medicine. I suspect that the greatest number of this forty percent is made up of primary care physicians and results greatly from the extent which government has intervened in medicine in terms of reimbursement and federal regulations. We must come up with some plan that will continue to encourage highly motivated, capable, dedicated individuals to choose medicine as a career, particularly primary care specialties.

In summary, rural health care and the quality of life in rural America is in jeopardy. The government can make a difference and I wish I felt confident that the government and the congress will support all the pending legislation that could help to solve the rural health crisis. The job is difficult and I realize that convincing your urban counterparts to support rural medicine is going to be a very difficult task. It is imperative that you are successful.

Thank you again for coming today and taking an interest in this very important concern of ours.

GORDON MEMORIAL HOSPITAL

STATEMENT OF CYD JANSSEN

Senator **KERREY**. The next witness is Cyd Janssen from the Gordon Memorial Hospital.

Ms. **JANSSEN**. I would like to start today by thanking you both for coming out west here. It is nice of you to take the time, the energy, and effort to give us a voice in our governmental process.

I would like to split my testimony today into two main segments. Both of the issues have the same common theme, but they deserve separate time and attention.

First of all, I would like to congratulate Senator Kerrey for his vision and foresight expressed in the farm bill deliberations by challenging the committee. I have it right here everybody. Challenging the committee to approach the table at a bipartisan matter—that is extremely important, and we are at the same point in health care.

We do not have the time, and we do not have the money to make it a partisan issue. We are all in trouble. We are in serious trouble in rural America. We need some help. It is not just one party's problem. It is everyone's problem. And the problem is that it interfaces and intertwines confusingly with other major national health issues: specifically, our economy.

We need to take some strong policy action before our economy drives us to some quick reactions. Some of the issues that we have heard about today are overregulation, excessive cost of regulations, unequal availability of resources, unequal payments, inequality of access, excessive costs. Charges are meaningless in this day and age. The increasing fragmentation, segmentation, complication, and improper focus payments and rewards are based on approaching death as a medical event not a normal occurrence of life as it is.

There is not a lot of profitability in preventive health; therefore, there is not a lot of focus on it. Poor resource management complicates things at all levels of the system as do conflicts within the system again at all levels. This includes overuse of technology to prevent or to practice defensive medicine. Efficiency versus effectiveness becomes an issue, as does technology duplication. That is not as big of a problem out here as it is in urban areas. We do not have a CAT scan on each corner. It would be nice, but we do not.

All these issues boil down to the common theme. Cost shifting does not work any more. It does not work, and it is not fair. It causes touchy problems all the way through our system, and we cannot get rid of it until someone with some authority decides to throw the conflict on the table and decides, is health care a right or a service purchased by those who can afford it? And if so, what are the levels that can be purchased onward and upward from there.

Knowing those rules would make our business a lot easier, because knowing the rules would help us to know our behavior.

I think it is wonderful to have Senator Kerrey and Senator Daschle present today as we are close neighbors as States. The dual presence of these two gentleman tells me they have the insight to understand the conditional sensitivity that Nebraska and South Dakota have for each other.

I am from Gordon, NE, and we are a border town of your State, and, therefore, we see and care for clients that come from your State as well as from Nebraska. One of our big problems I know is one of your problems, and I think it is a problem of every State in this Nation: Medicaid. I think you mentioned earlier that this is a tremendous problem.

To review, Medicaid is a program that is funded between the national and the State level. Right there we have our first fragmentation; however, the structure and the operations of that program are primarily State responsibility. Again we have another fragmentation. Problems that occur when we have fragmentation between States.

If we look at the Oregon project of rationing health care, we are to assume that the borders of that State are impermeable. States bordering Oregon will notice a shift in their Medicaid budgets. It will be a definite growth; therefore, this principle exhibits that one State's rationing is not cost saving. It is another clever cost shifting. Someone is picking up the bill. People will go to areas where conditions are favorable to meet their needs and their wants. There must be a sensitivity to our neighbor's policy. States cannot divorce themselves from the responsibility of working closely inside and outside of their own geographical areas. Long-term impact and the ripple effect must be considered from all angles, from both a State and a national level. We no longer have time for short-term profiteering, and that is exactly what cost shifting is.

It certainly distorts our reality, because there is no true savings for problems within Nebraska itself.

I am a home health nurse, and we deal a lot with social services. Our local office is in the county seat which is Rushville. They are accountable partially to the Chadron office who is then accountable to the Alliance office who is then accountable to the Gering office who is then accountable to the Scottsbluff office who is then accountable to Lincoln. Are you confused yet? How can we hold these good people accountable when they do not know who they are accountable to? Plus, the tremendous fragmentation causes fragmentation of service availability.

Service availability in Cherry County, which we go into, are not available in Sheridan County, yet it is the same system—I do not understand that—therefore, the clients suffer, and the system is supposedly for them.

The legislative intent to have a local office, which I appreciate, was commendable, but somewhere we lost our expertise, and we need to hang onto both of them to retain the accountability.

In summary, what does Nebraska need to do? We need to save some money. We do not have a lot of money. We need to simplify our current system. I do not believe we need a new system, a new structure, or new social programs. We need to recognize that the systems we have are codependent. Social systems are dependent on the medical system and vice versa. Cost saving in one cannot mean cost cutting in the other. We do not need to threaten jobs. We just need to help current structuring work so that people do their jobs with accountability from the national level to State level to county level, and I think we should have a regional level in there too.

Work together, and that means bipartisan. I know that is awfully hard to do, but we are adults now, and we are out of money. You ask how can Congress better assist in improving reform and how can these initiatives be used to improve Nebraskan health care? My answer is: Just do your part to keep the simple structure working. Work with us.

An example is looking at regulations; excessive regulations cost us all a bunch of money. Sometimes we have regulations that we need for a State level and they are not needed for a Federal level and vice versa. This is ludicrous. If it is not important for one level, why do we really need it for the other level? Help us shake these issues out. Work with us in identifying these problems and realize a true cost savings instead of adding just another shift.

Senator Kerrey, last time we met, you pointed out Nebraska has it all. It has rural. It has urban. It has all aspects of the United States reflected within our own State. Could we be a model for the Nation? Senator Daschle, you would be interested in my response, because you have the same characteristics in South Dakota.

My answer is: Yes; and you only need to do the things we have learned in kindergarten. Follow the rules, be nice to our neighbors, and nice to people and respect others. Thank you for the opportunity.

PREPARED STATEMENT

Senator KERREY. Thank you, Ms. Janssen. We have your prepared statement and it will be inserted in the record.

[The statement follows:]

STATEMENT OF CYDNEY D. JANSSEN, RN

Thank you for coming to western Nebraska—your efforts to give us a voice in the governmental process is greatly appreciated!

I would like to split my testimony into two main segments today. Even though the issues I am to speak about have a common root, they both deserve separate time and attention. Then I will summarize and comment on where we are and what meaningful interventions we could give at this time.

PART I.—I'd like to begin by congratulating Senator Kerrey for vision and foresight expressed during the Farm Bill deliberations by challenging the committee to approach the table in a bipartisan manner. I know that you both are aware that health care, in general, needs this tactic and strategy. All of us represented here today can attest that rural health cannot survive lengthy discussions on capitol hill—we are in trouble and we need help NOW. A wallet biopsy will also prove that our national health care problems can no longer afford a partisan and fragmented approach. It is not just one party's problem, it belongs to ALL of us. It interfaces and entwines confusingly with other major national issues, especially our general economics.

Before coming today I made a list of the types of problems I expected to hear testimony on, and they include the following:

1. Over-regulation and excessive cost of meeting regulations
2. Unequal availability of resources (manpower, technological and financial)
3. Unequal payments between the rural and the urban
4. Inequality of access—problems with timeliness
5. Excessive costs, out of control charges, and charges that are more and more meaningless.
6. Increasing fragmentation—segmentation—and complication
7. Improper focus—payments and rewards are based on approaching "death as a medical event," instead of a normal life phenomenon. Preventative health is not profitable, and therefore not pursued as intently as illness is.
8. Poor resource management (human, financial and technological.)
9. Conflict within the system—at all levels. (This includes overuse of technology to practice "defensive" medicine; efficiency vs. effectiveness; and technology duplication.

All of these listed issues boil down to a main theme that COST SHIFTING DOES NOT WORK ANYMORE AND IT IS NOT FAIR! It causes touchy problems all the way through our system. We cannot get rid of cost shifting until someone with the authority throws conflict on the table and demands a decision of the question: IS HEALTH CARE A RIGHT? OR IS HEALTH CARE MERELY A SERVICE THAT MAY BE PURCHASED BY THOSE WHO CAN AFFORD IT? This one decision would align and formulate a more clear framework for the medical field to practice in. Knowing the rules makes knowing one's behavior easier.

PART II.—It is nice to have both Senator Kerrey and Senator Daschle present today as we are close neighbors. The dual presence of these two gentlemen tells me that they have the insight to understand the conditional sensitivity that Nebraska and South Dakota have for each other. I am from Gordon, Nebraska and we are a "border town" of South Dakota. We therefore see and deliver cares to clients from both states. One of the problem area for Nebraska, as well as all states in the union, is our Medicaid. To review, Medicaid is a program with funding responsibility which is shared at state and national levels. The program structure and operations, however, is primarily the individual state's responsibility. Therefore we not only have fragmentation at the national level, but between states. Two of the general problems caused by this fragmentation include:

1. PROBLEMS WITH FRAGMENTATION BETWEEN STATES.—Looking at the Oregon project of "rationing" health care leads us to believe that the borders of that state are not permeable. States bordering Oregon probably will notice a shift in their Medicaid budgets—a definite growth direction. The principle exhibited here is that one state's rationing is not truly a "cost-savings," but merely another form of cost-shifting. Persons will go to areas where conditions are favorable to meet their needs and wants. Basic fundamentals of capitalism exist even within our nation's social welfare system. There must be sensitivity to our neighbor's policy. States cannot divorce themselves from the responsibility of working closely inside AND outside of their own geographical area. Long term impact and the ripple effect must be considered from all angles. From both a national and state level, we no longer have time or money for short-term profiteering, or cost-shifting. It certainly distorts our reality into believing that one party is "saving" money when there is actually not a realistic cost savings.

2. PROBLEMS WITHIN NEBRASKA.—We deal with the Social Service office in our local county, based out of the county seat, Rushville. The Rushville personnel are accountable to the citizens of Sheridan county to do the work of Social Services. Part of the responsibility for the function and supervision of the Rushville office is delegated to the Chadron office, and the rest of the responsibility is delegated to the Alliance office. These three offices are then overseen by the Gering office, which is under the supervision of the Scottsbluff office. The Scottsbluff office is then directly accountable to the Lincoln office. Are you confused yet? How can we hold the workers in these fragmented offices accountable to anything? This tremendous fragmentation of the system causes extreme fragmentation for service availability between areas. For example, our Home Health covers portions of Cherry and Sheridan county. Services available to Medicaid and Title 20 clients in Cherry county are not always available in Sheridan county, and sometimes one county will even tell me that such a program never existed! Therefore the client suffers although the system supposedly exists *for* the client. The legislative intent for Medicaid was commendable, as it focused on giving local control, but these programs have gotten SO local they have lost their expertise.

SUMMARY

What does Nebraska need to do?

Save money, by:

Simplifying our current system—We do not need a new system, a new structure, or new social program. We need to recognize that the systems are co-dependent. We do not need to threaten jobs, we just need to help current structures work so that people can do their jobs WITH accountability.

National
State SIMPLIFY THE STRUCTURE AND LET IT WORK!
Regional
County

The only way to successfully do this is for each of the levels to work *together,* and this means BIPARTISAN. We are shifting the risk back to where it belongs—to all of us. Therefore when you ask, "How can Congress better assist in improving reform initiatives?", my answer is "Just do your part to keep the simple structure working. Work *WITH* us, especially at the state level. An example would be looking at regulation. We already know that excessive regulation costs all of us a bunch of money. Can you help us streamline regulations? I never understand when people surveys say to me, "We do not need that, but the State (or federal) surveyor does." If it is not important for one level, is it truly necessary for the next? Help us shake out these issues and then realize a *true* cost savings instead of simply another cost shift. Senator Kerrey, last time we met you stated that, "Nebraska has it all. It has rural and urban, all aspects of the United States are reflected in Nebraska. Can we be a model for the nation?" Senator Daschle, you will be interested in my response because your state has it all too. My answer is YES! And we only need to do things that we all learned in Kindergarten:

1. Follow the rules

2. Be nice to our neighbor and nice to people.
3. Respect others.

Thank you for the opportunity to voice my thoughts with you today.

STATEMENT OF DR. JOHN SHAFFER

Senator **Kerrey**. Next witness is Dr. John Shaffer in Mitchell, NE.

Dr. **Shaffer**. Good afternoon, Senator Kerrey, Senator Daschle, rural health care providers, colleagues, rural health care consumers.

As a provider of rural health care, I wish to thank the Senators for this opportunity to share with them and their respective concerned committees my views of the future of rural health care. As a family physician I am one of the so-called primary care physicians. I have been such for 23 years, most of the time a solo practitioner. I not only practice medicine, but I also run a business of which I am sole proprietor, business manager, employer, and overall decisionmaker. Thus I have problems of two worlds, medicine and business.

I am now facing the real possibility that I will be forced out of the business of medicine in the near future because of the increasingly complex regulation of my practice of medicine, by State and Federal governments and by other third parties.

This complex regulation has resulted in the significant increase in the cost of my doing business plus a significant decrease in the reimbursement for my services; however, I wish to make it very clear that I came to this hearing to support my patients who have become the real victims of government-regulated medicine.

Rural Nebraska recipients, Medicare recipients, receive far less reimbursement for medical care than most others. Also I am quite pessimistic about the problems which have been created by our Government, primarily cost, and if I understand correctly, the Government subsidies have been greatly reduced. Certain premises exist in the minds of Federal bureaucrats.

No. 1: Physicians are not very good at practicing medicine.

No. 2: Physicians are dishonest.

No. 3: Physicians are held to superhuman standards.

No. 4: Physicians do not deserve to make a living based on the work ethic.

There are also, in my mind, other bureaucratic opinions which must be dispelled before Government and medicine will be able to work together to provide necessary and adequate medical care to everyone in this country. I know that not all physicians have all the desired qualities; however, most of us very sincerely and honestly practice the best of medicine, and I do feel that we should not be taken to task for those problems of other physicians.

The Medicare system administered by the Health Care Financing Administration, or HCFA, knows who the other few are, so why not go after them and then deal honestly and fairly with us and our patients? The rules and regulations implemented by HCFA at the direction of our Congress have compromised my ability to take care of my patients and to earn a reasonable income.

The rules and regulations have caused the following problems in my office:

No. 1: Massive confusion about filing Medicare claims.

No. 2: Inconsistent reimbursement.

No. 3: Denial of reimbursements.

No. 4: Patients' misunderstanding about Medicare reimbursement.

No. 5: Office staff frustration. This is increased primarily because of all the hassles related to Medicare and other third-party payers. Also it is becoming quite apparent that as office income falls so will wages and benefits thus making it more difficult to hire competent employees in a solo practice office.

Now, I realize that almost all of my comments are related to Medicare, but almost 75 percent of my patients are Medicaid or Medicare recipients. Three years ago I became a participating physician. I chose to participate in Medicare for one reason only and that reason was to give my elderly fixed-income patients the best of my services for the lowest out-of-pocket expense to them. Therefore, as I stated at the beginning, I may be forced out of business.

Financially, other problems related to Medicare exist:

No. 1: Because of low reimbursement income, I am unable to compete in the recruitment marketplace for physicians to join my practice.

No. 2: Because of Medicare denials, not only in office reimbursement but in hospitals and school nursing care situations, patients have become disgruntled with their physicians who have to make appropriate decisions based on Medicare and Medicaid and other third-party rules.

These decisions are becoming more frequent and, of course, as many of these decisions—which are unpopular to the patient and his family—are made, the more the physician bears the brunt of blame for insensitivity and lack of compassion.

This may lead to further patient and family discontent and perhaps eventually malpractice litigation which certainly increases the cost of medicine to everyone.

The bureaucracy has devised a very clever scheme to place the blame on physicians for the inadequacies of the Medicare system where, in fact, the blame should be placed on bureaucracy itself.

No. 3: Rural health care currently is based on primary care providers who are physicians.

Only physicians are highly trained enough to be responsible for an entire gamut of medical care. The physician is responsible for generating all, and I mean all, of the cost of medical care. No one else does it. Solutions to the problems, in my humble opinion, probably must be based on Government realization of what life is.

What is life worth? Is it 12, 13, 15 percent of gross national product? Is that too much to pay? I do not know. If it is, then the numbers of dollars provided for medical care will certainly have to be reduced.

With the new technologies and our abilities to keep people healthier for longer lives medical care will necessarily become more expensive. I have outlined in my written brief other solutions. I will not delve into those, because I see my time is up. I do appreciate the opportunity to have been here. I hope our input will help you to help us. Thank you very much.

PREPARED STATEMENT

Senator **Kerrey**. Thank you very much, Dr. Shaffer. We have your prepared statement and it will be inserted in the record.

[The statement follows:]

Statement of J.C. Shaffer, M.D., FAAFP

As a provider of rural health care, I wish to thank the Senators for this opportunity to share with them and their respective concerned committees my views of "The Future of Rural Health Care".

As a family physician I am one of the so-called primary care physicians. I have been such for twenty three years, practicing mostly as a solo physician. As a solo physician, I not only practice medicine throughout the full scope of medicine, but I also run a business of which I am the sole proprietor, business manager, employer and over-all decision maker. Thus I must cope with all the problems of the two worlds, medicine and business.

Thus far I have been able to adapt to the rules and regulations of business, but have had to hire help: accountants, attorneys, insurance agents, pension planners, and others. And thus far I have succeeded in the business of private solo practice of medicine in rural Nebraska.

However, I am now facing the real possibility that I will be forced out of the business of medicine in the near future, not because of the burden of running the business, but because of the increasingly complex regulation of my practice of medicine by State and Federal governments and by other third parties. This complex regulation has resulted in a significant increase in the cost of my doing business plus a significant decrease in reimbursement for my services.

Before I proceed, I wish to make clear that I came to this hearing to support my patients who have become the real victims of government regulated medicine. Rural Nebraska Medicare recipients receive far less reimbursement for medical care than most others. I also must state that I am pessimistic about solutions to the problems which have been created by our government, the primary one being the high cost of funding Medicare programs. If I understand correctly, the government intends to reduce these costs.

Thus I quote the following from John Kenneth Galbraith, American economist; "Only the man who finds everything wrong and expects it to get worse is thought to have a clear brain."

I fear, based on my twenty-three years in the private practice of rural medicine, that our current Medicare system represents most everything wrong, and I certainly do not think it will soon be better, if ever.

Certain premises exist in the minds of the Federal Bureaucracy:

1. Physicians are not very good at practicing medicine (otherwise why so many regulations concerning patient care).
2. Physicians are dishonest (otherwise why threats of punishment such as fines and imprisonment).
3. Physicians are held to superhuman standards (no physician should ever make a mistake).
4. Physicians do not deserve to make a living based on the work ethic (otherwise why would Medicare reimbursement levels be so low).

There are, in my mind, other Bureaucratic opinions which together with those outlined above must be dispelled before government and medicine would be able to work together to provide necessary and adequate medical care to everyone in this country.

I know, and you know, that not all physicians have all of the desired qualities; some are dishonest, some are not good at practicing medicine, some think they are superhuman, and some do make excessive incomes. However most of us very sincerely and honestly practice the best of medicine, and I do not feel we should be taken to task because of the other few. The Medicare System administered by the Health Care Finance Administration (HCFA) knows who the "other few" are, so why not go after them and then deal honestly and fairly with us and our patients.

The rules and regulations implemented by HCFA, at the direction of our Congress, have compromised my ability to take care of my patients and to earn a reasonable income.

The rules and regulations have caused the following problems in my office (and I am sure most other private medical offices):

1. Massive confusion about filing of Medicare claims. The rules seem to change almost daily, and it is impossible to keep up with those changes.

2. Inconsistent reimbursements, i.e. different amounts for same services. This makes keeping an accurate accounting system almost impossible (and certainly confuses my computer which I purchased to solve just these types of problems).

3. Denial and/or reduction of reimbursement which are also sometimes inconsistent. The cost of appealing denied or reduced claims has risen steadily, and accounts for a major portion of my increased overhead.

4. Patient misunderstanding about Medicare reimbursement in general. I was under the impression that Medicare Program was to hold public education seminars, but to my knowledge these have not taken place.

5. Office staff frustration has increased because of all of the hassles related to Medicare and other third party payers. Also, it is becoming apparent that as office income falls, so will wages and benefits, thus making it more difficult to hire competent employees in a solo practice office.

6. Many other problems to numerous for this presentation.

I realize that almost all of my previous comments relate to Medicare, but almost 75 percent of the patients in my practice are Medicare or Medicaid recipients. Therefore you can understand my profound concern.

Three years ago, I became a "participating physician," meaning that I contracted with HCFA to accept whatever dollars Medicare allowed as payment in full for all services I rendered to Medicare patients. Often third party payers offered the same; I respectively have declined to participate with them because of low fee schedules.

I chose to participate in Medicare for one reason only, and that reason was to give my elderly fixed-income patients the best of my services for the lowest out-of-pocket expense to them. That decision decreased my income and increased my overhead. In most practices, that discrepancy is adjusted by regular fee paying patients, i.e. private pay patients and private insurance. However, in a Medicare-age dominated practice like mine, I cannot make up that difference. Therefore as I stated at the beginning I may be forced out of business financially.

Other problems related to Medicare exist:

1. Because of low reimbursement and income, I am unable to compete in the recruitment market place for physicians to join my practice.

2. Because of Medicare denials, not only in office reimbursements, but in hospital and skilled nursing care situations, patients have become disgruntled with their physicians who have to make appropriate decisions based on Medicare and Medicaid and other third party practice guidelines and rules. These decisions are becoming more frequent, resulting in denial of hospital or skilled nursing home continued stays, and sometimes in denial of hospital admissions. Of course, as more of these decisions unpopular to the patient and his family are made, the more the physician bears the brunt of blame for insensitiveness and lack of compassion. This may lead to further patient and family discontent, and perhaps eventually malpractice litigation which certainly increases the cost of medicine to everyone. The bureaucracy has devised a very clever scheme to misplace the blame on physicians for the inadequacy of the Medicare system, where, in fact, the blame should be placed on bureaucracy itself.

3. Rural Health Care currently is based on the primary care providers who are physicians like Drs. Sorensen, Bjorling, Cornelius and me. Only physicians are highly trained enough to be responsible for the entire gamut of medical care, i.e. the physician is responsible for generating all (and I mean all) of the costs of medical care. No one else at this time can definitively order hospitalizations, treatments, drugs, operations, etc., for any patient. If this appropriate situation is to continue, then more physicians will have to be recruited to rural areas.

4. Many other problems exist, but I will enumerate no further.

Solutions to the problems, in my humble opinion, may be very difficult because of governmental mandated reduction of costs in the Medicare program, whether it be urban or rural.

I surmise that the expenditures will have to be based on the government's value of life.

How much is a life in these United States worth? Is 12, 13, or even 15 percent of the Gross National Product too much to pay for medical care in these United States? If it is, then the numbers of dollars provided for medical care will certainly have to be reduced. Given the new technologies and our abilities to keep people healthier for longer lives, medical care will necessarily become more expensive. Therefore I submit the following very undesirable circumstances may have to occur:

1. Denial of certain care to certain populations.
2. Rationing of health care.
3. Total socialization of medicine.

Other alternative solutions which may be more desirable may include the following:

1. Reduction of regulation of medical practice.
2. More patient participation in paying for care, i.e., allow those who are financially able to pay, pay.
3. Take to task those physicians, and also those patients and medical suppliers, who abuse the system, and allow those of us who try to be fair and honest practice without undue threats and restraints.
4. Spread the dollars. As all of us know, reimbursement is very unequal, especially here in rural Nebraska. Therefore the bottom line for maintenance of the current availability of care is more dollars. Congress recently considered legislation which would increase the Prevailing Charge Floor for Physicians. I would urge our Senators strongly to consider this proposed change. In addition, Oregon Senator Packwood is sponsoring the "Rural Health Improvement Act", and I would again urge our Senators to support this legislation.
5. The new Resource Based Relative Value System for physician reimbursement does have merit, but would not be implemented until 1992. By that time I foresee further emigration of physicians from rural Nebraska, and further decline of the availability and quality of health care. Therefore I recommend Congressional passage of the two previous proposals.
6. A less desirable partial solution may be employment of more paramedical personnel in rural areas, i.e. physicians assistants and nurse practitioners. How this would affect the quality of care I do not know, but would be a concern.

Again, Senator Daschle and Senator Kerrey, thank you for your time and consideration relative to the plight of Rural Health Care. I hope that our participation here today provides you and your colleagues, and our government, with necessary input. We are concerned that our patients will eventually be without appropriate medical care, and I think that none of us should allow that to happen.

STATEMENT OF DR. SORENSEN

Senator **KERREY**. The next witness—I got you confused with the other internist—Dr. Sorensen, also Scottsbluff Internal Medicine.

Dr. **SORENSEN**. 2 West 42nd Street, Scottsbluff.

I am very pleased to have the opportunity to testify on the future of rural health, and I wish to express my gratitude to Senator Kerrey and Senator Daschle for their efforts in bringing the hearing to western Nebraska.

We have reached a critical stage in the division of health care services to the rural citizens of our Nation.

In recent years there are shortages of care providers in virtually all areas of the country and closures of small rural hospitals continues unabated. Many believe that the reasons for these problems lie with Federal programs which have resulted in steady operating losses for rural hospitals and reduced incomes for rural practitioners. The impact of these programs cannot be denied and have been discussed extensively both here and elsewhere.

There are many other factors which contribute to the problems experienced in rural communities including the increasing complexity of modern medicine and the reliance on high technology and high-cost procedures which can only be provided in settings where there is sufficient activity to justify the expense. To this must be added the perception that bigger is better which results in the more mobile segments of the rural population.

Those with the ability and resources to travel long distances for care seek services in cities rather than staying at home. In order to reverse these trends, the quality of the care provided in rural settings must be every bit as good as that provided in cities, and the local residents must perceive this to be the case.

Additionally, rural citizens must come to understand that the higher the level of services they wish to have available to their communities, the more they must be willing to subsidize these services as low volumes and acceptable fees will not generate revenue sufficient to cover the cost.

I believe the establishment of a regional network encompassing the entire range of services from primary to tertiary levels will be required to satisfy these needs. These networks will have responsibilities for provision of services including determination of manpower and equipment needs, recruitment and retention activities, quality insurances and utilization review, and training and continuing medical education.

They will be able to address some of the major issues in rural health care today such as trauma and medical emergency, backup relief, and financial stability. These networks will be composed of primary care centers in the small communities, secondary hospitals in larger towns, and a tertiary center in the city. The establishment of such networks will require emphasis on new emergency medical services and transport along with high technology communication systems such as teleradiology.

The primary care centers will be provided state-of-the-art diagnostic and therapeutic equipment appropriate to the level of care being delivered at each site and will be staffed variously by physicians, physician assistants, and nurse practitioners as appropriate to the setting, confident and efficient care as close to home as possible when a patient requires services beyond the capability of the primary care center: Proper transportation will be provided to the nearest tertiary facility.

Without some form of organization either with this model or something similar, I believe we will find, as indeed we are finding now, that we will be unable to meet the medical needs of rural Americans. In the near term there remain a number of problems which require attention.

Congress has addressed many of the financial issues impacting rural health care by changing reimbursement policies for rural hospitals and by adopting resource based relative value scale for rural physicians; however, the schedule phase-in of the RBRBS may come too slowly to be too much help.

For this reason I would urge you to consider adding your support to, which I am glad to hear you have already done, to the Rural Health Improvement Act introduced by Senator Packwood which would accelerate the enactment of RBRBS.

I would also ask that you consider carefully the impact of all health-related legislations, specifically, on rural practitioners and hospital legislation which may have desirable effects significantly different implications for much smaller rural communities which do not benefit from economies of scale. The institution of diagnosis-related groups represents just such legislation as do some of the concepts currently being considered which could have the impact of restricting access to essential services in primary care centers.

The regulations currently established for physician office laboratory services, which would limitedly apply to primary care centers, could have the effect of making unavailable laboratory studies which are relied upon regularly to provide care to patients.

In closing, I would like once again to express my appreciation to you for bringing this hearing to Scottsbluff. While I share the concerns of everyone here for the future of health care in rural America, I believe we have opportunities before us to make major contributions to the health of our rural citizens. Thank you.

PREPARED STATEMENT

Senator **Kerrey**. Thank you. We have your prepared statement and it will be inserted in the record.

[The statement follows:]

Statement of Todd S. Sorensen, M.D.

I am very pleased to have the opportunity to testify on the Future of Rural Health, and I wish to express my gratitude to Senator Kerrey and Senator Daschle for their efforts in bringing the hearing to Western Nebraska.

We have reached a critical stage in the provision of health care services to the rural citizens of our nation in recent years. There are shortages of care providers in virtually all areas of the country and closures of small rural hospitals have continued unabated.

Many believe that the reasons for these problems lie with Federal programs which have resulted in steady operating losses for rural hospitals and reduced incomes for rural practitioners. The impact of these programs cannot be denied and has been discussed extensively, both here and elsewhere. There are many other factors however which contribute to the problems experienced in rural communities, including the increasing complexity of modern medicine and the reliance on high technology and high cost procedures which can only be provided in settings in which there is sufficient activity to justify the expense. To this must be added the perception that "bigger is better," which results in the more mobile segments of the rural population, those with the ability and resources to travel long distances for their care, seeking services in cities rather than staying at home.

In order to reverse these trends, the quality of the care provided in rural settings must be every bit as good as that provided in cities and the local residents must perceive this to be the case. Additionally, rural citizens must come to understand that the higher the level of services they wish to have available in their communities, the more they must be willing to subsidize these services, as low volumes and acceptable fees will not generate revenue sufficient to cover the costs.

I believe the establishment of regional networks encompassing the entire range of services from primary through tertiary levels will be required to satisfy these needs. These networks will have responsibility for provision of services including determination of manpower and equipment needs, recruitment and retention activities, quality assurance and utilization review, and training and continuing medical education. They will be able to address some of the major issues in rural health care today, such as trauma and medical emergency management, backup relief and financial stability.

These networks will be composed of primary care centers in the small communities, secondary hospitals in larger towns and a tertiary center in a city. The establishment of such networks will require new emphasis on Emergency Medical Services (EMS) and transport, along with high technology communications systems such as teleradiology.

The primary care centers will be provided with state of the art diagnostic and therapeutic equipment appropriate to the level of care being delivered at each site and will be staffed variously by physicians, physician assistants and nurse practitioners as appropriate to the setting. Competent and efficient care will be provided as close to home as possible, and when a patient requires services beyond the capability of the primary care center, prompt transportation will be provided to the nearest appropriate secondary or tertiary facility. Without some form of organization, either with this model or something similar, I believe we will find, as indeed we are finding now, that we will be unable to meet the medical needs of rural Americans.

In the near term, there remain a number of problems which require attention. The Congress has addressed many of the financial issues impacting rural health care by changing the reimbursement policies for rural hospitals and by adopting the Resource-Based Relative Value Scale. For rural physicians, however, the scheduled phase-in of the RBRVS may come too slowly to be of much help. For this reason, I would urge you to consider adding your support to the Rural Health Improvement Act introduced by Senator Packwood which would accelerate the enactment of the RBRVS.

I would also ask that you consider carefully the impact of all health-related legislation specifically on rural practitioners and hospitals. Legislation which may have desirable effects in large urban areas may have significantly different implications for much smaller rural communities which do not benefit from economies of scale. The institution of Diagnosis Related Groups (DRG) represents just such legislation, as do some of the concepts currently being considered which could have the impact of restricting access to essential services in primary care centers. The regulations currently being established for physician office laboratory services, which would presumably apply to primary care centers, could have the effect of making unavailable laboratory studies which are relied upon regularly to provide care to patients.

In closing, I would like once again to express my appreciation to you for bringing this hearing to Scottsbluff. While I share the concerns of everyone here for the future of health care in rural America, I believe we have opportunities before us to make major contributions to the health of our rural citizens.

STATEMENT OF SANDY SCOFIELD, STATE SENATOR FROM NEBRASKA

Senator KERREY. The next witness is State Senator Sandy Scofield.

Senator SCOFIELD. Thank you, Senator Kerrey. It is good to have you here. I would also personally like to thank you for taking the trouble to come before this group this afternoon and talk to both Senator Kerrey and Daschle, and I know there are some other elected officials in the crowd besides myself, and we learn every time you take the time to come out and give us your insights which we need to understand.

The complexity of the issues that we have heard here this afternoon obviously have started us really on a journey that you started some months ago, Senator Kerrey, and I am happy to see Senator Daschle here with you as well. I do not think we are going to resolve this immediately. It is the kind of issue that is going to require, I think, more meetings like this, continued analysis by health care providers, insurance people, private business representatives, elected officials, and consumers, and so on. It is the kind of issue that raises not only financial questions but service delivery questions and philosophical questions talked about here today.

It is going to take us some time to resolve. I would like to suggest that at least in the meantime probably the first priority has to be the addressing of the problem with the reimbursement systems. However, I do not think that is the full completion of the journey even if we are successful, as I hope we will be, in addressing that reimbursement issue. It is almost like getting those little tires that you get to carry you to the next town. You would not want to drive very far on those things, but we do need that tire desperately in terms of addressing the financing problems so that we just continue to have health care in rural Nebraska.

I appreciate both of your willingness to avoid the temptation to just find one quick fix and go home. This is a very complex issue. It is going to take us a long time probably to really come up with some solutions that will carry us into the next century, but reimbursement issues are the first priority. Beyond that, my thoughts largely come from my experience as a State legislator serving on the appropriations committee where we see the impact of Federal decisions on our budget that have been made in terms of health care.

Medicaid happens to be the biggest problem with the State budget as I am sure you know, Senator Kerrey, because of your experience as Governor. I firmly believe that the best system is going to return more decisionmaking authority closer to home, closer to the consumer, closer to the provider, and that cannot just be in Lincoln. I think we all know Lincoln well enough to know that that is not close enough to come up with solutions that will serve us somewhere out here.

There is considerable difference from my experience in the way things happen in Lincoln. We solve their problems. We still have not solved the problems in the panhandle. So I think it is extremely important that we address those organizational issues. If we are successful in moving some of the decisions closer to home and avoiding the temptation that the feds have had lately to not only leave us alone which is sometimes good news, but they take their money with them which is bad news.

We need to get those decisions closer to home, and I am confident we can address more effectively those questions of access and quality and come up with solutions that are innovative, realistic and reasonably sensitive, not to mention cost effective, which is critical.

We heard everybody say that costs are going to go up, and I do not think any of us doubt that. I think that is even more true in a rural area with an aging population and the other demographics. Just transportation issues are one thing that we have to address, so I would stress that I see this as a long journey, and we are going to have to continue on with work to address that.

Nevertheless, I see that time is of the essence in terms of the financing issue. If we are unsuccessful in solving that in a relatively short period of time, the system will collapse, and we will not have any system that we can tinker with and come up with better long-term solutions.

So I thank you again for your time for being here. I look forward to working with you and other people in this room in the future on these issues.

Senator KERREY. Thank you, Sandy.

I am going to close this formal part of the hearing with a couple of statements. One is that the advantage of holding a formal Senate hearing in our home State is that the quality of the witnesses is significantly less in Washington than what we have heard today. We hear lobbyists in Washington. We do not hear the personal experiences of individuals, that of family physicians who provide, I think by everybody's analysis, the lowest cost care in our entire health care system.

So I appreciate your participation very much. I just want to point out that it is important that you have taken the time to come down here. I would also reiterate what I said at the start: The record is open for 1 week, and I know how difficult it can sometimes be to make some notes, but there are three or four areas that I in particular—and I am sure Senator Daschle—would love to get in the record.

You need not be terribly formal with this thing, but it would be a particular help to me if I could hear from individual working people who are struggling with the cost of health care, getting insurance, or having problems, perhaps, with transferring from one job site to another: "We are trying to move from welfare to the working ranks and find health care to be a significant barrier." We have heard a considerable amount about how the problem could be an insufficient element of business control in the system. On the other hand, the small business people very often find themselves up against great odds in trying to provide any kind of health coverage to their employees.

If any of you are business people or know small business people—that includes self-employed farmers and ranchers—that might be able to give us very important insight on how to do this thing right that we did not hear about today, I would appreciate hearing from you. I am especially interested in any comments we could get in the area of emergency care, particularly rural emergency care—that is extremely important, and as I have heard on other occasions is under a significant stress as well.

We did not hear much on dental or allied health. I would appreciate it very much if any of you who have experience in that area could provide some written testimony. It would also be helpful to find anyone who has an opinion or experience with pharmaceuticals, with prescription drugs. There is very little government involvement in pharmaceuticals other than regulating the introduction of them. There is a considerable amount of concern over the cost and access there as well.

CONCLUSION OF HEARINGS

I will at this point close the hearing by very sincerely thanking all of you for coming out here on a Sunday afternoon. Neither Senator Daschle nor I reach immediate conclusions when we hear this kind of testimony, but I assure you it links together and becomes a very important part of our conclusions. We have got an awful lot of additional information. I am beginning to get a pretty good list of agenda items that I think would help, particularly in the area of primary care in rural areas, not only in relation to reimbursement but also in the regulatory area referred to.

I thank you all very, very much for coming out here this afternoon.

[Whereupon, at 2:50 p.m., Sunday, June 3, the hearings were concluded and the subcommittee was recessed, to reconvene subject to the call of the Chair.]

MATERIAL SUBMITTED SUBSEQUENT TO THE HEARING

[Clerk's Note.—The following statements were not presented at the hearing, but were submitted to the subcommittee for inclusion in the record subsequent to the hearing:]

STATEMENT OF JAMES L. CORBIN

Suggestions to Improve the Medicare Problem:

1. Expand "The Prospective Payment System" to cover Part B of Medicare.

A. Require all "health care providers" serving Medicare-Medicaid Recipients to accept as "Payment in Full" the amount Medicare approves.

I. To do this Medicare approved amount must be generally acceptable and it is within Congress' power to do this.

2. Require all insurance companies to use one standard form thus eliminating the very complicated and confusing forms used by some.

3. Very important. When establishing approved amounts be certain that areas being served are treated equally when local costs are much higher for some reason.

4. Educate the recipients: I have not seen any education about Medicare and related health care concerns since moving in Nebraska in 1986. H.C.F.A. was in the field a lot in Colorado and was a great help.

Things that I believe should be investigated:

1. I have heard several times that if a Medicare patient has Medigap insurance with the same company that is the company that is handling medicare in the area the dollar amount approved by Medicare in higher for these Medicare patients.

a. I was shown Medicare "Explanation of Benefits" that appeared to me to verify this.

2. I do not believe that rural areas such as Scottsbluff have or are being properly considered by Medicare in established the approved amount.

a. I refer you to the enclosed copy of the response that I received from Medicare to my inquiry as to whether the amount approved was correct.

I called your attention to item 3 which says in part, the prevailing charge for this area. I read this area to be the Topeka, Kansas area.

Another part under item 3 says in part, "This is the amount which is high enough to cover the customary charge in three out of four bill for this service. Question: 3 out of 4 bills where? Certainly not around here.

I am told that just 30 miles from here in Torrington, Wyoming, generally Medicare approved a higher payment than here.

A very major problem that needs to be alleviated is the extremely high costs health care is costing those older Americans who are not eligible for any of Medicare's Part A benefits without purchase of Part A.

Part B can be purchased at an affordable price, but not so of Part A.

Medigap Insurance:

s

1. All Medigap Insurance providers should be governed the same.

2. All Medigap Insurance providers should be required to offer three (3) basic coverages:

a. Pay all deductibles and the 20 percent of approved charges not paid of Medicare.

b. Same coverages as A plus a standard Prescription medicine benefit.

c. Coverages same as A & B plus paying in full the amount of the providers bill not paid by Medicare.

Some Medigap Insurance pays some or all of the amount the Provider charged above the amount approved by Medicare.

a. Generally, but not all, have an amount deductible before this coverage is implemented, however some, if not all, have a clause giving the decision as to the reasonable amount charged by the provider.

This can and perhaps does by giving 100 percent of the control to the insurance company eliminate some companies from ever paying on this coverage.

Some Medigap Insurance companies are not under the control of state insurance department.

a. Some might be classified as prepaid health care. Some interstate congress should enact laws to bring all under the same control.

I believe that if you investigate you will find that other recipients collect only about 80 percent of the amounts due them from Medicare and or Medigap Insurance.

"For ten years I was very active in assisting and educating people about Medicare and Medigap Insurance and several times I assisted in recovering money due.

Usually, but not always, from Insurance Companies,

MIKE CORBIN

Take a look at what is happening to lots of our older citizens:

1. Medigap Insurance has gone up an inappropriate amount.

2. Interest on savings has gone down.

3. Our COLAs haven't kept up with our additional costs and nothing replaces our loss of income on investments.

STATEMENT OF ALAN JOHNSON, M.D.

Senators Kerry and Dashcle:

First I want to thank you for making us feel that our thoughts regarding rural health care in America are valuable.

I wish to address one issue only. I would rather take on a new Medicaid patient than a Medicare patient. I have been in Family Practice for 14 years in Gering, Nebraska. I have become increasingly more disgruntled with the Medicare program over the years. Statistics from the American Medical News, May 18, 1990 include that rural area have more elderly, poor, less on Medicaid, more insured, more chronic disease, and less primary care doctors than urban areas. I feel a humane obligation to care for the poor, but I do not feel I have to provide cut-rate services to someone just because they are over 65. Many of my older patients would gladly pay a more realistic office call charge but now must do without because our reimbursement rates are less than urban areas and that's where the doctors are going. Same number of old people, less doctors. Any reason you can think of for me to fill my office appointments with visits that don't even pay the overhead?

Solutions: fair compensation for primary care, equal pay for all parts of the country. Then no shortage of doctors here.

Respectfully,

Alan Johnson, M.D.

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STATEMENT OF GLADYS GREEN, A.R.T.

Concerns in Health Care

I feel we need to keep working to even the payments per DRG between rural and urban hospitals. Rural hospitals are greatly needed in our area due to the distances between towns. For instance, our next closest hospital, roughly 50 miles away to the west,, and east to Valentine is 90. It is vital to have a Gordon Hospital, very sick and very elderly cannot travel great distances to other hospitals. Supplies cost more in rural hospitals that urban due to delivery charges and lower volumes in ordering. Our technical people's wages need to be comparable to urban employees as we are in competition for well trained personnel to work in our hospitals and have to pay comparable wages to get them.

PROPAC should help. We need to keep DRG payments the same to rural and urban hospitals.

We need help for education for rural students in health professions to encourage rural youth to take training in these areas as rural areas face a shortage of trained people to stay there.

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STATEMENT OF SHELLEY ANDERSON

Governor Orr:

On April 8th, I lost my little sister. She was also pregnant with twin boys. We lost them also.

My sister Pam did not even know she was carrying twins, nor did her doctor.

Pam was seen by Dr.____________________in Omaha one time in her fourth month. She was 7 months along when she passed away.

Pam made several other appointments with the doctor's office, but was told she could not come in until she had over $850 cash in hand.

On March 19th I saw Pam's Dr. and told her that Pam was very swollen and going numb on one side. Dr. _______ did not seem the least bit concerned and gave me a ridiculous excuse for Pam going numb. She should have called Pam and told her to come in and ask Pam if she had other symptoms. Dr. ________ had not seen Pam in over two months. It has always been stressed to all pregnant women how important it is for prenatal care.

Pam came from a middle class family. Her husband is a truck driver and makes a good living, but not good enough to come up with that kind of money. They also did not have health insurance.

On April 8th, because of the doctor's neglect to her patient, Pammy and her babies passed away.

What is becoming of the medical world today? Is that all they care about is the money? That people are being neglected and turned away because they cannot afford medical care? Something has got to be done. How can you put a dollar value on a human life?

Let me tell you a little about Pam. She always had the biggest smile on her face and she loved people and life. She always looked past the bad in everyone and saw only the good. If Pam only had the clothes on her back and someone needed them, she would of gave them the clothes off of her back. On last x-mas 89' she wanted a kitten and not just any kitten. She wanted a kitten from the humane society. She wanted to save it's life. Her husband Breeze took Pam to the humane society in Fremont. Pam picked out the sickest kitten there. They told her not to take that one because it was very sick. Pam said I want this kitten from the humane society. She took it straight to the vet. The vet told Pam to take the kitten back and get her money back for it. She refused so he gave the kitten its shots and medicine. I have a poem and one verse says if love could of saved you, you never would have died. Pam's love saved that kitten. She gave it all the love in the world. I now have that kitten.

Pam had so much to offer it is truly a great lost to us all.

We need more people in this world like Pam.

How many more people have been turned away from drs. or hospitals because they did not have health insurance or could not afford to pay?

How many more will have to die needlessly?

Why can't the government take care of us all. The state pays for the health care of convicted criminals in our penitentiary and jails around the state and they consist of murders, rapists, and thieves.

The Canadian government takes care of their own, why can't we take care of our own? I wouldn't even care if taxes were raised in order to cover health care costs for everyone.

I know that you are in the race for re-election. Why aren't there any politicians taking about health care. I would like to see this issue talked about and brought to everyone attention. I am asking you for your help. Please don't let me letter me unnoticed and thrown on a big pile or thrown in a trash case.

Please help us all. I truly believe that if we can get health care for everyone in the state of Nebraska that maybe the other states will also do something for their citizens.

If we can save just one person in Pam's shoes then all of our efforts have been well worth it.

We can't bring Pam back but maybe this is a good enough reason for us to fight for health care for everyone.

Please sent me a reply to my letter to just let me know you have received it.

Thank you very much.

Shelley Anderson

LETTER FROM LINDA L. GWYNN

Senator Robert Kerry
194 Dirksen
Washington, D.C. 20510

Dear Senators Kerry and Daschle,

I have been requested to submit written testimony concerning issues in Rural Health Care. I am an Accredited Record Technician and my main responsiblity at Gordon Memorial Hospital is functioning as the Utilization Review Coordinator and DRG Coordinator. These responsibilities bring to mind every day several problems that impact rural health care which I would like to share with you.

There are numerous cumbersome regulations that are imposed on rural hospitals in order for them to participate in the Medicare Program. Most of these requirements are extremely costly to hospitals and no provision for hospitals to recoup the cost is available. One requirement that is an absolute necessity is conducting utilization review on all Medicare patients and pre-procedure review for 10 specific surgical procedures. Medicare requires hospitals to review the following: Re-admissions within 30 days to insure that the previous discharge was appropriate; all patients transferred from our facility to another DRG facility to insure that their transfer was appropriate; all cost and day outlier cases; Admission patterns; a minimum of 10% of all other hospital admissions; extended stays; and all Hospital Issued Denials. In addition, Medicaid patients are required to be "precertified" prior to admission, or shortly thereafter and provide updates every 3-5 days. (Several private Health Insurance Companies have also instituted "precertification".) In order to meet this requirement Gordon Memorial Hospital spends 20-25 hours per week doing chart review, precertification, continued certification, etc. This is the equivalent of one part-time person. This person is required, by Medicare, to perform these duties regardless of the cost to the hospital.

It is the consensus by HCFA that Rural Health Care Facilities should be able to provide quality health care to Medicare participants at less cost than an urban hospital. This thinking results in decreased reimbursement in the rural DRG payment system. I would like to point out a few fallacies of this thinking.

1. In order to obtain and retain Professional Staff, rural hospitals have to have a comparable wage for Professional Staff, regardless of the "Community/Area Wage Index".

2. Supplies are more costly. This is due to a number of factors, which include the fact that less supplies are needed in a rural area, and quantity discounts/prices are not available and because the distance of many Rural Health Care Facilities to a major supplier is greater and harder to access, the shipping costs are more.

3. High-tech equipment is as costly for Rural Health Care Facilities as it is for urban hospitals. (If not more so, due to the added cost for shipping.)

In Rural Health Care Facilities, the majority of patients are Medicare. At Gordon Memorial Hospital the percentage is approximately 80%.

Rural Health Care Facilities are being forced time and time again to cut back and trim the budget. Sooner or later the quality of health care to all patients will be affected.

Provisions should be made for hospitals when they have to write off accounts after numerous attempts of collecting are unsuccessful. Because of their ruralness, (The closest hospital to us is 45 miles west.) rural hospitals feel obligated to treat any patient regardless of their ability (or usually inability) to pay for the services. This results in a significant economical impact to the hospital. Perhaps the inability to pay is due to the fact that the wage index in rural communities is much lower than urban areas and because "Insurance" is as expensive for rural people as urban people, the rural people do without it. Another factor could be that in an 'urban area, there are bigger companies i.e. Con Agra, AT&T, etc, who provide, (as a benefit) health insurance to their employees and rural area employers cannot afford to provide this benefit.

When these people without health insurance in rural areas are faced with hospitalization, they often will turn to the State for assistance. Reimbursement from State Medicaid Programs is an extremely low perdiem, which does not even come close to the actual cost (not to mention charges).

Another problem that faces Gordon Memorial Hospital daily is the fact that we are a bordertown. This results in transfers from the Pine Ridge Public Health Service Hospital (PHS) and South Dakota Medicaid recipients. Both of these types of patients have their hospitalization paid for by the DRG payment system. The reimbursement is the same as the reimbursement under the Medicare System. This is a double whammy to Gordon Memorial Hospital that most rural hospitals do not have to contend with. If the Medicare reimbursement is unfavorable it carries over to the PHS and South Dakota Medicaid reimbursement. This is another significant economical impact to our rural hospital.

I sincerely appreciate both of your efforts and concern for Rural America. Quality health care is important to all American citizens, whether they are Medicare, Medicaid recipients, or private pay recipients and whether they live in a rural or urban area. If drastic measures are not taken soon, not only will the quality of rural health care be in jeopardy, but the ability to provide rural health care will no longer exist.

Thank you for the opportunity to provide this written testimony.

Sincerely,

Linda L. Gwynn

Linda L. Gwynn

LETTER FROM WENDELL FAIRBANKS, M.D.

May 29, 1990

Patricia K. Redel
Western Nebraska Representative
2106 1st Avenue
Scottsbluff, NE 69361

Dear Ms. Redel:

The following are my comments concerning the problem of health care in Rural Nebraska since I will be unable to attend the meeting.

I have worked all of my professional life in under-served areas in rural Nebraska, initially in southeast Nebraska in Auburn for 13 years and now in Alliance Nebraska for 13 years. All of these 26 years have been involved in continuous recruiting efforts to get more physicians to come to rural Nebraska. With this experience, I have a great deal of information on why doctors will not come to our rural areas. Currently one of the most pressing problems is Medicare reimbursement. Nebraska receives a great deal less payment for the same medical care that is paid to physicians on either coast for the same care. Rural Nebraska receives a great deal less payment for the same care than is received by those patients in the larger cities in Nebraska, (Lincoln and Omaha). This being the case, those of us in rural Nebraska receive nearly the lowest payment for medical care of anywhere in the nation. New physicians coming into practice can go to other areas, see the same number of patients and make a much better living than those of us in rural Nebraska. Recently having attended a rural health manpower meeting in Alliance, I was amazed that I continue to work in rural Nebraska since they very strongly pointed out all of the disadvantages and very few advantages for working here. Our medical group has been taking few or no new Medicare patients for some years since each time a Medicare patient is admitted to one of our exam rooms, it displaces a paying patient. More importantly, we receive at least weekly and sometimes daily information about further resrictions on how we may treat patients and the length of time they need treated or even how many times they can be seen for their illnesses in any one month, and warnings of the dire penalties that will be levied on us such as monetary fines or even jail sentences if we are not in compliance. We are also told that if we innocently make a mistake, we are still subject to those penalties. This is a very intimidating situation. It is a negative reward system in that the harder we work and the more we do, the more chance we have for exposure to the penalties of the Medicare Program. Several of the medical newspaper type journals have mentioned physicians around the country not only refusing to take new Medicare patients but actually dismissing those from their practice that they have already been caring for. Our group is certainly becoming disillusioned with the Medicare program and the Government in general and may also consider this option.

In summary, those of us in rural Nebraska nearly the lowest level in the United States for taking Medicare patients. We are being intimidated by the Government and told how to practice, how much care a patient can receive. We feel that we are rendering care in an undeserved area and should be rewarded for working on the frontier not penalized.

The solution is to immediately increase the fees paid to rural physicians to equal those of the physicians rendering the same care in the cities along the coast. Even the military increases the pay for their people working in hazardous situations as flying, etc and working in rural Nebraska certainly qualifies as hazardous duty.

Sincerely,

Wendell Fairbanks, M.D.

STATEMENT OF BLUE HILL CLINIC

BLUE HILL CLINIC
SUMMARY OF SIGNIFICANT PROJECTION ASSUMPTIONS AND ACCOUNTING POLICIES
Year Ending December 31, 1989

NOTE C-BANK BORROWINGS AND INTEREST EXPENSES

The projections assume that the Company will obtain debt of $80,000 to fund the purchase of the Blue Hill clinic and debt of $30,000 to fund start-up expenses, in the first quarter of 1989. Using current interest figures obtained from the Franklin State Bank, the clinic debt was estimated to be amortized over 240 months at an interest cost of 10.5%. Start-up expenses will include a computer system and a phone system. Interest on this note payable was computed at a fixed rate of 11% with a term of 84 months. Monthly installment payments on both notes will begin immediately. Although educational debt is not an expense of the business, it is shown for the purpose of providing adequate cash flow to pay off the educational debt. It is computed on $30,000 for 84 months with an interest rate of 11%.

NOTE D-OPERATING EXPENSES

Wages

This amount is based on one receptionist at $5.85 an hour and one nurse at $5.85 an hour for 52 weeks.

Insurance

Malpractice insurance is based on the actual paid by Dr. Houston which is $7,216 per year. A new doctor does not pay in full the first couple of years with a tail to pay when he leaves the profession. Therefore, the difference between the full amount and the actual paid will leave enough money to pay insurance on the business property.

Professional Coverage

A doctor can expect to take at least one weekend off per month and a two week vacaton off during the year. This estimate is what it would cost to get a doctor to come in during time off. This cost is based on what Dr. Houston has to pay for a replacement in Franklin.

Payroll Taxes

This estimate is based on the above wage amounts with the employer's share of social security and federal and state unemployment.

Contract Labor

This estimate is for the business management advice contracted from Jill Houston during the first year. She will be working as a professional and not an employee of the new doctor.

UNDERSTANDING MEDICARE REIMBURSEMENT TO PHYSICIANS IN RURAL NEBRASKA
AND
COMPARING THE IMPACT OF RURAL REFORM PROPOSALS BEING CONSIDERED BY CONGRESS

Republican Valley Medical Management considered the possibility of starting a clinic in Blue Hill, Nebraska in late 1988. To evaluate the financial market a CPA was hired to do a cost projection. Actually two cost projections were developed: one projected the physician as a Medicare Participant and the other as a Medicare Non-participant. Both projections were bleak. Educational debt and start up costs made starting the clinic financially impossible for either the participating or the non-participating physician. Blue Hill has not replaced its' retired physician. Physicians today cover Blue Hill from Hastings and Red Cloud on a part-time basis.

Even though the Blue Hill Clinic never was, it can be useful as a model to discuss Medicare physician reimbursement. The projections are well outlined by the CPA and their authenticity is as good as any projection's authenticity can be. What I propose is to use the Blue Hill model to discuss variables in Medicare reimbursement. I will not make multiple financial sheets. I will simply discuss variables and how they relate to the bottom line.

VARIABLES	PARTICIPATING	NON-PARTICIPATING
New Private Practice	$ 9,060	$37,572
Paid Education Debt	$15,228	$43,740
Paid Startup Costs/Established	$21,396	$49,908

The above table compares the income of the physician starting a rural practice without assistance to one who has assistance with startup costs and educational debt assistance. The established physician has usually paid off educational debt and startup costs. Their income is most consistant with the "paid startup costs" values. The above table also compares the income of the participating and non-participating physician.

Public Health Care in rural Nebraska IS the physician in small towns like Blue Hill. It IS the hospital and physicians in communities like Franklin. Florida and New York have networks of health department clinics and federal health clinics to fall back on. Our state has private MDs, traveling nurses and county hospitals. We are literally the last line of defense for our rural citizens. Unfortunately our Medicare reimbursement is not commensurate with that responsibility.

Congress in 1987 passed legislation to protect physicians who were on the bottom end of the reimbursement schedule. This Prevailing Charge Floor for Primary Care Services was set at 50% of the Estimated National Prevailing Charge for that service. If a local par prevailing charge was below the 50% national par, the physician would be paid the national "floor" rate. The chart on the back of this page gives an itemization of these "floor" rates compared to rural Nebraska rates. The table below shows how these "floors" would effect the Blue Hill clinic.

VARIABLES	50% FLOOR	RURAL NE PAR	80% FLOOR	NATIONAL PAR
Private Prac.	$ 656	$ 9,060	$35,316	$58,296
Paid Education	$ 6,824	$15,228	$41,484	$64,464
Paid Start Up	$12,992	$21,396	$47,652	$70,632

There is no question that Nebraska's rural physicians are being underpaid by Medicare. What are the solutions? The most talked about solution today is the Resource Based Value System or RBVS that was passed by Congress last year. The RBVS is a good program but it alone will not meet the needs of rural Nebraska. As currently planned the RBVS will begin to be phased in in 1992. Current estimates are that rural physicians MAY see a 20% raise in their reimbursement that year with a total reimbursement raise of 32% over four years. After holding hearings in his own state of Oregon, U.S. Senator Robert Packwood introduced his "Rural Health Improvement Act". This act will provide the complete 32% RBVS increase in 1992. The chart on the back of this page gives an itemization of the impact the RBVS will have on rural Nebraska reimbursement. The table below shows how the RBVS would effect the Blue Hill clinic.

VARIABLES	RBVS AT 20%	RBVS AT 32%
Private Practice	$35,649	$44,728
Paid Education Debt	$41,817	$50,946
Paid Startup Costs	$47,985	$57,114

Looking at the above figures one can see why rural physicians are not satisfied with the RBVS program. If mandatory assignment passes in 1992 and Senator Packwood's bill fails, the non-participating physician in 1989 will take home less money in 1992. Even if the "Rural Health Improvement Act" passes, the participating physician in 1992 will be paid almost $15,000 less than his "average" colleague was paid in 1989. The root of the problem is seen in the table at the bottom of page 1. Rural Nebraska is approximately at a 60% floor. A 60% floor is 40% LESS than the national average. You need a 66% RAISE to get back to the national average. You need a 100% raise to get from a 50% floor to a national average. The percentages are working against us.

To achieve equity in Medicare reimbursement the percentage mathematics of the RBVS must be tempered with a convergent "floor" and "ceiling". The AMA, the PPRC and the National Rural Health Advisory Committee all agree that raising the "floor" is a possible solution. In fact a raised floor combined with the RBVS holds the best opportunity for rural Nebraska to obtain parity. The third chart itemizes this well and the following table shows the impact on the Blue Hill Clinic.

VARIABLES	1992 RBVS	1989 NATIONAL PAR	1992 PACKWOOD
Private Prac.	$48,492	$58,296	$59,828
Paid Education	$54,660	$64,464	$65,996
Paid Startup	$60,828	$70,632	$72,164

I fervently petition all of you who read this report to take action to support Senator Packwood's "Rural Health Improvement Act" and to solicit our U.S. Senators to sponsor legislation to "Raise the Prevailing Charge Floor for Primary Care Services to 80% of the Estimated National Average Prevailing Charge." If the 80% Medicare Floor legislation passes for 1991 it will result in a $26,256 increase for our Rural physicians per year ($47,652-$21,396). If both the "Rural Health Improvement Act" and the 80% "floor" legislation are passed it will be a $49,236 increase in 1992 ($72,164-$21,396). To keep physicians in rural Nebraska and to successfully recruit new ones we HAVE to offer at least an average wage. Rural Nebraskans desperately need those physicians.

ROBERT E. HOUSTON M.D.

PREVAILING CHARGE FLOORS AND RURAL NEBRASKA MEDICARE REIMBURSEMENT

SERVICE	HCPCS CODE	1989 PREVAILING CHARGE FLOORS PARTICIPANTS	1989 NATIONAL PREVAILING PARTICIPANTS	1989 RURAL NEBRASKA PAR PREVAILING	80% PREVAILING CHARGE FLOORS PARTICIPANTS
OFFICE VISIT					
MINIMAL	90030	8.90	17.80	10.00	14.24*
BRIEF	90040	10.10	20.20	12.20	16.16*
LIMITED	90050	12.00	24.00	16.00	19.20*
INTERMEDIATE	90060	15.07	30.14	16.20	24.11*
EXTENDED	90070	21.60	43.20	(21.40)	34.56*
COMPREHENSIVE	90080	31.21	62.42	40.50	49.92*
HOUSE CALL					
BRIEF	90140	15.58	31.18	24.50	24.93*
LIMITED	90150	18.37	36.74	20.50	29.39*
INTERMEDIATE	90160	21.60	43.20	30.00	34.56*
EXTENDED	90170	27.85	55.70	(25.00)	44.56*
EXTENDED CARE					
BRIEF	90340	11.74	23.48	17.75	18.78*
LIMITED	90350	14.05	28.10	15.00	22.48*
INTERMEDIATE	90360	16.20	32.40	21.60	25.92*
EXTENDED	90370	21.61	43.22	40.00	34.58*
NURSING HOME					
MINIMAL	90430	12.00	24.00	12.00	19.20*
BRIEF	90440	10.78	21.56	12.20	17.25*
LIMITED	90450	13.03	26.06	16.00	20.85*
INTERMEDIATE	90460	18.02	36.04	(16.20)	28.83*
EXTENDED	90470	20.44	40.88	21.40	32.70*
EMERGENCY ROOM					
MINIMAL	90530	9.40	18.80	15.00	15.04*
BRIEF	90540	11.31	22.62	15.50	18.10*
LIMITED	90550	14.32	28.64	26.50	22.91
INTERMEDIATE	90560	16.36	32.72	27.00	26.18
EXTENDED	90570	24.15	48.30	28.10	38.64*
COMPREHENSIVE	90580	30.24	60.48	36.50	48.38*

SOURCES:

Medicare Carrier Instructions (5260. Floor for Primary Care Services, 11-88, Rev. 1279)
Nebraska 1989 Medicare Charge Profile Report, Locality 16.

The above figures are published averages and do not represent any particular physician's fees or charges.

The 1989 prevailing charge floors were set by Congress at 50% of the 1989 National prevailing charges. The above figures are calculated from the charge floors.

(1989 rural par is less tha 50% "floor") * 80% floor exceeds the 1989 rural par.

RURAL NEBRASKA IMPACT OF 1992 RBVS PROPOSALS COMPARED TO 1989 MEDICARE NATIONAL AVE. REIMBURSEMENT

SERVICE	HCPCS CODE	1989 RURAL NEBRASKA PAR PREVAILING	1992 RBVS PPRC PROJECTION AT 20%	1992 RBVS SEN PACKWOOD AT 32%	1989 NATIONAL PREVAILING PARTICIPANTS
OFFICE VISIT					
MINIMAL	90030	10.00	12.00	13.20	17.80
BRIEF	90040	12.20	14.64	16.10	20.20
LIMITED	90050	16.00	19.20	21.12	24.00
INTERMEDIATE	90060	16.20	19.44	21.38	30.14
EXTENDED	90070	(21.60)	25.92	28.51	43.20
COMPREHENSIVE	90080	40.50	48.60	53.46	62.42
HOUSE CALL					
BRIEF	90140	24.50	29.40	32.34*	31.18
LIMITED	90150	20.50	24.60	27.06	36.74
INTERMEDIATE	90160	30.00	36.00	39.60	43.20
EXTENDED	90170	(27.85)	33.42	36.76	55.70
EXTENDED CARE					
BRIEF	90340	17.75	21.30	23.43	23.48
LIMITED	90350	15.00	18.00	19.80	28.10
INTERMEDIATE	90360	21.60	25.92	28.51	32.40
EXTENDED	90370	40.00	48.00*	52.80*	43.22
NURSING HOME					
MINIMAL	90430	12.00	14.40	15.84	24.00
BRIEF	90440	12.20	14.64	16.10	21.56
LIMITED	90450	16.00	19.20	21.12	26.06
INTERMEDIATE	90460	(18.02)	21.62	23.79	36.04
EXTENDED	90470	21.40	25.68	28.25	40.88
EMERGENCY ROOM					
MINIMAL	90530	15.00	18.00	19.80*	18.80
BRIEF	90540	15.50	18.60	20.46	22.62
LIMITED	90550	26.50	31.80*	34.98*	28.64
INTERMEDIATE	90560	27.00	33.40*	35.64*	32.72
EXTENDED	90570	28.10	33.72	37.09	48.30
COMPREHENSIVE	90580	36.50	43.80	48.18	60.48

SOURCES:

Medicare Carrier Instructions (5260. Floor for Primary Care Services, 11-88, Rev. 1279)
Nebraska 1989 Medicare Charge Profile Report, Locality 16
American Medical News, May 25, 1990 (PPRC and Sen Packwood % projections 1992)

The 1989 National Participant values were calculated from the 1989 prevailing charge floors. Congress set the "floors" at 50% of the National Par Prevailing.

The above figures are published averages and do not represent any particular physician's fees or charges.

(1989 50% "Floor" value)   * value exceeds the 1989 National Par Prevailing.

RURAL NEBRASKA IMPACT OF 1992 RBVS PROPOSALS COMBINED WITH A 1989 80% PREVAILING CHARGE FLOOR

SERVICE	HCPCS CODE	1989 RURAL NE PAR PREVAILING + 80% FLOOR	1992 RBVS PPRC PROJECTION AT 20%	1992 RBVS SEN PACKWOOD AT 32%	1989 NATIONAL PREVAILING PARTICIPANTS
OFFICE VISIT					
MINIMAL	90030	(14.24)	17.09	18.80*	17.80
BRIEF	90040	(16.16)	19.39	21.33*	20.20
LIMITED	90050	(19.20)	23.04	25.34*	24.00
INTERMEDIATE	90060	(24.11)	28.93	31.83*	30.14
EXTENDED	90070	(34.56)	41.47	45.62*	43.20
COMPREHENSIVE	90080	(49.92)	59.90	65.89*	62.42
HOUSE CALL					
BRIEF	90140	(24.93)	29.92	32.91*	31.18
LIMITED	90150	(29.39)	35.27	38.79*	36.74
INTERMEDIATE	90160	(34.56)	41.47	45.62*	43.20
EXTENDED	90170	(44.56)	53.47	58.82*	55.70
EXTENDED CARE					
BRIEF	90340	(18.78)	22.54	24.79*	23.48
LIMITED	90350	(22.48)	26.98	29.67*	28.10
INTERMEDIATE	90360	(25.92)	31.10	34.21*	32.40
EXTENDED	90370	40.00	48.00*	52.80*	43.22
NURSING HOME					
MINIMAL	90430	(19.20)	24.04	25.34*	24.00
BRIEF	90440	(17.25)	20.70	22.77*	22.62
LIMITED	90450	(20.85)	25.02	27.52*	26.06
INTERMEDIATE	90460	(28.83)	34.60	38.06*	36.04
EXTENDED	90470	(32.70)	39.24	43.16*	40.88
EMERGENCY ROOM					
MINIMAL	90530	(15.04)	18.05	19.85*	18.80
BRIEF	90540	(18.10)	21.72	23.89*	22.62
LIMITED	90550	26.50	31.80*	34.98*	28.64
INTERMEDIATE	90560	27.00	33.40*	35.64*	32.72
EXTENDED	90570	(38.64)	46.37	51.00*	48.30
COMPREHENSIVE	90580	(48.38)	58.06	63.86*	60.48

SOURCES:
Medicare Carrier Instructions (5260. Floor for Primary Care Services, 11-88, Rev. 1279)
Nebraska 1989 Medicare Charge Profile Report, Locality 16
American Medical News, May 25, 1990 (PPRC and Sen Packwood % projections 1992)

The 1989 National Participant values were calculated from the 1989 prevailing charge floors. Congress set the "floors" at 50% of the National Par Prevailing.

The above figures are published averages and do not represent any particular physician's fees or charges.

(1989 80% "floor" value exceeds NE Par) *value exceed the 1989 National Par.

LETTER FROM MARGARET M. SIEL, CERTIFIED PUBLIC ACCOUNTANT

I have compiled the accompanying projected cash flows of the Blue Hill Clinic for the year ending December 31, 1989, in accordance with standards established by the American Institute of Certified Public Accountants.

The accompanying projections and this report were prepared for the purpose of recruiting a new doctor to the Blue Hill Clinic and for presentation to Medicare showing the need for higher reimbursements.

A compilation is limited to presenting in the form of a projection information that is the representation of management and does not include evaluation of the support for the assumptions underlying the projection. I have not examined the projection and, accordingly, do not express an opinion or any other form of assurance on the accompanying statements or assumptions. Furthermore, even if each of the four circumstances were actually attained, there will usually be differences between the projected and actual results, because events and circumstances frequently do not occur as expected, and those differences may be material. I have no responsibility to update this report for events and circumstances occurring after the date of this report.

Margaret M. Siel, CPA

Margaret M. Siel
Certified Public Accountant

December 20, 1988

BLUE HILL CLINIC
PROJECTED CASH FLOW ASSUMING 100% REIMBURSEMENT BY MEDICARE AND HOSPITAL AND EMERGENCY ROOM INCOME FROM RED CLOUD HOSPITAL
FOR THE YEAR ENDING DECEMBER 31, 1989

Fee Income

Clinic	100 visits/wk	450 visits/mo	$ 9,000.00
House Calls	2 visits/wk	9 visits/mo	240.75
Hospital	3 adm/wk	13 adm/mo	812.50
Hospital	10 visits/wk	45 visits/mo	1,350.00
Nursing Home	10 visits/wk	45 visits/mo	1,201.50
Emergency	4 visits/wk	18 visits/mo	720.00
			$13,324.75
Estimated Billing Collectibility - 89.25%			$11,892.34

Expenditures

Note Payment - Clinic	$ 799.00
Note Payment - Start-up Capital	514.00
Note Payment - Educational Debt	514.00
Wages	2,028.00
Insurance - Malpractice and Business Property	601.00
Professional Coverage	900.00
Payroll Taxes	220.00
Supplies	500.00
Dues and Subscriptions	50.00
Repairs	50.00
Telephone	100.00
Freight/Postage	75.00
Travel	175.00
Miscellaneous	50.00
Medical Supplies	650.00
Utilities	200.00
Contract Labor - J. Houston	900.00
Lab Fees	50.00
Continuing Education	200.00
Legal and Accounting	100.00
Service Contracts	85.00
Total Expenditures Estimated	$ 8,761.00
ESTIMATED CASH FLOW TO GO TO DOCTOR PER MONTH	$ 3,131.00
ESTIMATED CASH FLOW TO GO TO DOCTOR FOR THE YEAR ENDING DECEMBER 31, 1989	$37,572.00
EDUCATIONAL DEBT PAID BY BUSINESS	6,168.00
TOTAL NON-BUSINESS CASH FLOW TO GO TO DOCTOR (Projected)	$43,740.00

See accompanying summary of significant projection assumptions and accounting policies, and accountant's report.

BLUE HILL CLINIC
PROJECTED CASH FLOW ASSUMING CURRENT MEDICARE REIMBURSEMENT - 80% PATIENTS UNDER MEDICARE AND HOSPITAL AND EMERGENCY ROOM INCOME FROM RED CLOUD HOSPITAL
FOR THE YEAR ENDING DECEMBER 31, 1989

Fee Income

Clinic	100 visits/wk	450 visits/mo	$ 7,596.00
House Calls	2 visits/wk	9 visits/mo	188.55
Hospital	3 adm/wk	13 adm/mo	755.30
Hospital	10 visits/wk	45 visits/mo	745.20
Nursing Home	10 visits/wk	45 visits/mo	819.90
Emergency	4 visits/wk	18 visits/mo	557.28
			$10,662.23
Estimated Billing Collectibility - 89.25%			9,516.04

Expenditures

Note Payment - Clinic	$ 799.00
Note Payment - Start-up Capital	514.00
Note Payment - Educational Debt	514.00
Wages	2,028.00
Insurance - Malpractice and Business Property	601.00
Professional Coverage	900.00
Payroll Taxes	220.00
Supplies	500.00
Dues and Subscriptions	50.00
Repairs	50.00
Telephone	100.00
Freight/Postage	75.00
Travel	175.00
Miscellaneous	50.00
Medical Supplies	650.00
Utilities	200.00
Contract Labor -J. Houston	900.00
Lab Fees	50.00
Continuing Education	200.00
Legal and Accounting	100.00
Service Contracts	85.00
Total Expenditures Estimated	$ 8,761.00

ESTIMATED CASH FLOW TO GO TO DOCTOR PER MONTH	$ 755.00
ESTIMATED CASH FLOW TO GO TO DOCTOR FOR THE YEAR ENDING DECEMBER 31, 1989	$ 9,060.00
EDUCATIONAL DEBT PAID BY BUSINESS	6,168.00
TOTAL NON-BUSINESS CASH FLOW TO GO TO DOCTOR (Projected)	$15,228.00

BLUE HILL CLINIC
SUMMARY OF SIGNIFICANT PROJECTION ASSUMPTIONS AND ACCOUNTING POLICIES
Year Ending December 31, 1989

NOTE A-NATURE OF PROJECTIONS

These financial projections are based upon a combination of two different assumptions and present, to the best of management's knowledge and belief, the Company's expected cash flow for the projection period if each of the four circumstances were attained. Accordingly, these projections reflect its judgment as of December 20, 1988, the date of these projections, of the expected conditions and its expected course of action if each of the four circumstances were attained. The presentations are for the purposes of recruiting a doctor to the Blue Hill Clinic and to present to Medicare the need for increased reimbursements. Accordingly, these projections may not be useful for other purposes. The assumptions disclosed herein are those that management believes are significant to the projections. Further, even if each of the four circumstances were attained, there will usually be differences between projected and actual results, because events and circumstances frequently do not occur as expected, and those differences may be material.

NOTE B-REVENUE

The number of visits per week and per month are based on the clinic and hospital census of the Franklin area, with adjustments made for varying conditions existing in the Blue Hill Clinic and for planned and expected changes in the market. The number of visits were extended at the current fee schedule and then reduced by 10.25% for uncollectible debts, the actual rate for Dr. Houston's office during the year 1987. Fees charges for each type of services is as follows:

		Medicare
Clinic Visit	20.00	16.10
House Call	26.75	19.50
Hospital Admission	62.50	57.00
Hospital Visit	30.00	13.20
Nursing Home	26.70	16.10
Emergency	40.00	28.70

The 80% patient base being under medicare is based upon the actual percentage in the Franklin clinic. Given the similar age strata in the Blue Hill versus Franklin clinic, the same percentage was used.

Currently, the majority of hospitalized patients go to Mary Lanning hospital in Hastings, instead of the Red Cloud hospital. The doctor in Blue Hill has no admitting priviledges with Mary Lanning and receives no income. The need for cooperation between Red Cloud and Blue Hill is evident. If patients are referred to and treated in the Red Cloud hospital, the doctor in Blue Hill would receive income from hospital related services. The projected cash flows present estimates with patients going to Hasings versus the Red Cloud hospital.

STATEMENT OF HAROLD L. KRUEGER, JR., ADMINISTRATOR, CHASE COUNTY COMMUNITY HOSPITAL

Call it a game, a system, a methodology, how the Federal Government beats the Rural Health Care Provider. Or maybe, how to dispose of a segment of society under the pretense of we're doing this for the betterment of mankind. Through continued Medicare budget cuts, we have the **Silent Rationing of Health Care going on in Rural America.**

The Bureaucracy that governs the Medicare system in affect, as told to us by a recent Medicare Patient, ... **are parallel the violations against Mankind that were inflected by Hitler and the Nazis.** She came through that system and should be a good judge of ours. You, Medicare selectively have condenmed the elderly and the impoverished to less than adequate Health Services, and in reality have sentenced them to die in an inhumane fashion; pain, loss of self worth, respect, denial of basic human rights.......... that of health and well-being

As a Rural Hospital Administrator, I have seen numerous individuals denied these basic rights through the narrow and limited views of the PRO, and Medicare Reviewers. Our Rural Hospitals provide the services necessary to these individuals, only to find weeks, months, later that their services have been denied. And we will not be paid for the basic life saving services provided. The Government, Medicare has now become a participate in the **rebirth of the Holocaust.**

We need your help and understanding of the many problems that Rural Health is facing. Through the restrictions of the Federal programs we are unable to provide the care our local residents need and deserve. **The inadequacy of funding** to the Rural Areas, 30,40 percent less and more, is forcing the closure or limiting the services of many Rural primary care facilities. The resulting band-aid stations will not keep our Communities and residents alive

Through the recent Medicare Area Wage Index revisions, the efficiency of the Rural Nebraska Hospitals were rewarded with a 9% reduction. This amounts to over a **$60,000.00 reduction** to my facility, more than the black ink on my bottom line! Yet, the Medicare Program has chosen to reward the inefficient Urban facilities, **Massachusetts increase will be over $68 Million, while Nebraska takes a $12 to $15 Million reduction. Quote Jimmy Carter, " Life ain't fair"..**

These funding hardships, **Rural Rationing**, are causing problems in the following areas:

1. Physician recruitment and retention. Family Practice
2. Specialty Physician recruitment and retention Surgeon, ENT
3. Registered Nurses
4. Recruitment of Physical Therapist, Lab and Radiology Technologists.

5. You name it, and it's in short supply in Rural America. (Except the under funded Medicare Recipients).

Assumptions are made that if you live and work in a rural area, that you can do so for less. This isn't true, especially in the environment of Health Care. **We compete with the Nation, at the National level in the recruitment of Physicians, Nurses and all Ancillary Support Professionals.** The other false assumption made, is that the supplies utilized by small facilities cost less. Manufactures, producers, only give discounts for volume purchases, so tell me how my overhead can be less than the larger Urban Facilities? Medicare feels that it is so, and reflects this attitude in our payment methodology.

However, tell me why the cost (Bill) to the Federal Government (Medicare) for like procedures, Daily Room Charges, Surgical Fees, etc., etc., is always less than that same procedure from the Urban facilities. Why we pay more (Medicare) to the East/West Coast Facilities than the Midwest? In America, I thought that we were equal? When Rural verses Urban, Rural is always less, because we give an honest days work, with not fat, we have no crystal in the waiting rooms, no McDonalds in the hallways and no piped music on the phones. **We give Medicare 100% in value for their 60% reimbursement.**

Give us your tired, your poor, your aged, this is the Rural America of today. I know that through lip service, meetings, memos and FAX's, you are addressing the plight of Rural Health, but fear not, when you (Government) have found the solution, there will be no problem. **The Rural Facilities of Nebraska will all have perished within the MEDICARE GAS FURNACES of funding.**

None of the above is new to you, we have been sending these same concerns to Washington for many years. Your trip to the panhandle of Nebraska will produce nothing, some expense for the taxpayers, a new feather for your war bonnet and continued lip service to the Rural Provider.

If you are interested in " **THE FUTURE OF RURAL HEALTH** ", then work for a system that is fair and equable in the area of reimbursement for both the Facility and the Physician. Work with us in this era of transition, encourage funding at the Federal level for the education of Physicians, Nurses and Allied Health Professionals with a forgiveness of payment if they provide services in the Rural or Underserved Urban Areas. The Rural Facility needs more cross-trained, multi-specialist employees, help us encourage our educational institutions into developing these programs. Provide us with the funding, professionals to address the reversal of the Hill-Burton era, when all towns were encouraged to build Health Care facilities. **We need help** in the development of plans that will allow for the systematic closure of under utilized Rural Facilities. With assurances to those communities that their health needs will and can be met. We no longer can afford a Hospital in every community, and don't have the professional resources, Physicians, Nurses, etc., to properly staff and maintain the Rural Facilities that we currently have.

We need a national/regional system of providing primary care at the local community level combined with a treatment, triage and transportation system at the regional level for those individuals needing expanded care. . **National Health Insurance is not the answer,** more Medicare funding will help solve the problems of today, but consolidation of our National Health Resources just might be the salvation of our future. . If we use what we have, **better,** maybe, just maybe, we might be able to afford the quality of health that we all desire.

Thank you for your time and concerns. If there is anything that I as a Rural Hospital Administrator can do, or provide for you, please ask.

Sincerely;

Harold L Krueger

Harold L. Krueger Jr.
Administrator/CEO

LETTER FROM DAN CLARK, M.D.

June 2, 1990

The Honorable Robert Kerry
United States Senator

Dear Senator Kerry:

I am a family practice physician, trained at the University of Nebraska College of Medicine, having spent my entire career in Gering-Scottsbluff after my internship in 1970. I have had the unfortunate opportunity to see an entire medical community change from a very content, happy, enthusiastic group of doctors to a collection of disgruntled, discouraged, disenchanted people. Whereas, just a few years ago, doctors were encouraging and coaxing young people--including their own children--to enter this wonderful profession, now I hear great restraint being expressed by virtually all of my colleagues when high school and college youths ask about the future of medicine in America. The warnings are especially strong regarding two aspects, with the message being: If you feel that medicine is really for you, don't consider the specialty of Family Practice; and, if you do end up in medicine, don't consider settling in Nebraska.

The interrelated reasons for this discontent are several, but the situation which specifically explains the difficulties in being in Family Practice in Nebraska centers upon the inequities in the Medicare/Medicaid reimbursement system. This system was unbelievably set up such that the hospitals and physicians who were charging large fees were rewarded, and those who had made it their practice to keep costs low were penalized. Physicians in rural America, and certainly in western Nebraska, have historically tried to supply medical care to their patients at as low a cost as possible, giving away thousands of dollars worth of free care every year. As a result, the bureaucracy has determined that it must be extremely cheap to be sick in rural communities, so reimbursement will be set at much lower levels in these areas. For the physicians, the end result has been that rural doctors just had to accept working for less money.

Not making the big dollars that our "city cousins" get is not a new idea, and it has never been much of an issue until now. Now we find that fewer and fewer well-trained doctors are willing to come to rural areas to work for forty-thousand dollars less than they are being offered in metropolitan areas, and especially so in cities in other states. Rural Nebraska, including Scottsbluff/Gering, has a serious need for more family physicians. As doctors retire, young trainees generally won't give our state a serious look when they compare salary offers in other areas.

The answer to the problem lies in equitable reimbursement. If doctors in Denver, New York, Seattle, and Cheyenne are being grossly overpaid by the government agencies, lower that pay. If rural doctors are being grossly underpaid, raise that pay. These widely divergent payment programs must be made more equal or the exodus of doctors from rural America will continue.

Respectfully,

Dan Clark, M.D.

STATEMENT OF DALE H. BROWN, PASTOR, FEDERATED CHURCHES

May 30, 1990

Re: Rural Health Care Hearing

Dear Senator Kerrey:

Thank you for the invitation to provide written testimony concerning rural health care. The major part of this testimony will be found in the attached survey. This survey was taken at The Federated Churches, Mitchell, Nebraska, on May 27, 1990. It is not in any way construed to be a scientific survey, but it does give a feel for the attitudes of at least this segment of citizens living in rural Nebraska.

Answers to the medical monster our society has created are complicated, and I find myself struggling between the ideal and realistic. It seems to me that government is faced with some major decisions in this area during the decade of the 90's. Indications are that no one (physician, hospital, insurance company, consumer) is willing to give. Physicians want to continue to be compensated at the present or higher rates; hospitals want continued profit and prestige; insurance companies want continued growth and profit; consumers want continued instant, quality care. We could also add pharmaceutical companies and attorneys to the list of those who want a piece of the pie.

But someone has to pay, and no matter how hard we resist, the government is ultimately going to be stuck with the tab, so it is time that government face that fact and dig in until the job is done. Naturally, the citizens are the ones who will bear the financial load, and some will scream and holler because of increased taxes, but, as I see it, there is no choice in the matter given the spoiled condition of our society. That, my friends, is the most realistic statement I can make.

However, as politicians work to design a medical plan for our country, I would hope that lowering medical costs would be a priority. As it is now, it is as if we were playing tennis with a cannon ball. Everyone knows that the ball is too heavy, but instead of considering options on how to make the ball lighter, they are designing mechanisms of greater power with which to throw the ball. Obviously, someone is going to get hurt. In the case of health care it will be the consumer.

It is my opinion that extravagance and abuse are rampant in the medical industry. How can we control it? Congress needs to seriously address this aspect of the problem.

In relationship to rural health care, the inequities in Medicare payments need to be corrected. But health care is not just a rural problem. It is a national problem that needs to be dealt with across the board, so that all citizens of the United States have access to medical care regardless of their ability to pay.

Respectfully submitted,

Dale H Brown

Dale H. Brown
Pastor

Results of Health Care Survey
Conducted at the Federated Churches
Mitchell, Nebraska, on May 27, 1990

Total surveys completed and returned: 87

1. How would you rate the quality of health care in our area?

Excellent	20%
Good	49%
Fair	29%
Poor	2%

2. In regard to the number of physicians practicing in our area, we have:

Too Many	0%
Enough	22%
Too Few	78%

3. Do you believe medical charges are reasonable?

Yes	23%
No	77%

4. Do you believe that it costs more for medical care in a metropolis such as New York or Chicago than it does in rural Nebraska?

Yes	27%
No	33%
Not Sure	40%

5. Have you experienced difficulty collecting insurance or Medicare?

Yes	20%
No	80%

6. Would you favor a national health insurance plan?

Yes	44%
No	10%
Not Sure	46%

7. Would you favor a tax increase to facilitate a national health insurance plan?

Yes	27%
No	38%
Not Sure	35%

COMMENTS GIVEN ON SURVEY:

1. We are thankful for our wonderful medical center and excellent doctors and nurses in this area.
2. Small towns need doctors!
3. Most doctors are only interested in monetary value. Most do not spend enough time to even know who you are. It is a sign of their interest when you are told bluntly that they will accept you as a patient if you are not on welfare. What are these people to do? We have good hospital facilities - too bad they are out of most people's range to use.
4. Need country doctors.
5. The quality of health [care] is poor for those who are aged, poor, near poor, or even lower middle class. Practices are closed to these groups who cannot afford health insurance for MD services or hospitalization.
6. Feel family doctors are needed.
7. [Question 5] Personally, no - Am insurance administrator at work, and people have had problems - feel this is widespread.

8. The Medicare system in rural Nebraska is very unfair. The people here should be collecting as much from Medicare as people in other areas.

9. Our rural area is losing doctors, stating Medicare payments as primary cause.

10. I feel older people are not being taken care of. It's taking everything they have worked for in life.

11. Definitely need more psychiatrists - services needed for the hearing impaired.

12. Medicare reimbursements should be the same for all parts of the United States.

13. Medical payments need to be raised to comply with the national average.

14. Surgery costs too high.

15. I won't doctor in Nebraska because it doesn't pay like other places, like Colorado and Wyoming.

16. Great difficulty in getting medical appointments. Doctors are overworked. There should be equality in Medicare all over the United states so that we can have more medical doctors in our area.

17. Surgery costs so high.

18. Insurance and Medicare reimbursement should be equal nationwide. Rural areas have the same requirements as metropolitan areas.

19. Rural areas should get the same benefits for Medicare and Medicade as the people in the city. This seems to me to be a fallacy.

20. Health insurance is to high. We know a couple who are paying $250 each month to Blue Cross for health insurance.

21. I think 20 million people have no health insurance. Those that have insurance the rates continue to raise. The rural people have to travel to Scottsbluff since we only have one doctor in Mitchell. Some couples are paying $250 apiece for Blue Cross, Blue Shield a month with $500 deductible. In Sweden the older people over 65 in car accidents are not given any mouth to mouth and they say about 12,000 are put away (to sleep). I do not believe in this. Taxes and utilities continue to go up and more people will not be able to afford insurance.

LETTER FROM JERRELL F. GERDES, ADMINISTRATOR, FRANKLIN COUNTY MEMORIAL HOSPITAL

June 1, 1990

Senator J. Robert Kerrey
United States Senate
Washington, D.C. 20510

Dear Senator Kerrey:

As a rural hospital administrator, over twenty years, I have witnessed many of the difficulties of providing medical care in rural Nebraska. In addition, I have reviewed several other states and have listened to the many problems faced.

In lieu of personal testimony, this letter is being provided to lend support to the efforts underway seeking to assist rural communities in providing medical care.

The Rural Primary Care Hospital Program and numerous other governmental programs seem to believe removal of acute care hospitals will solve the problems. It is my belief that "fair and reasonable" payments to our physicians will create more health care in rural areas.not elimination.

The proposed 80% Medicare Prevailing Charge for physicians in 1991 will do more to prevent loss of medical care than any program I have seen or read about. Certainly rural hospitals have not closed for lack of a Hospital Administrator or lack of funds. Harlan County, Webster County, and Garden County supported large dollar items this past May. You are also aware of the $500,000 voted by Oxford in 1987 and 1988 just to keep the doors opened.

All of these failures are related to shortages of family practice physicians not expense of having a hospitals. Webster County may have their problem corrected with two new physicians, but we all know that making $50,000-$70,000 in Red Cloud still pales when compared to Omaha at $100,000 and up. Cost of living changes but a physician is a physician regardless of where he lives.

Your interest and support of rural Nebraska and rural America in general is appreciated. Thanks for the support and we hope the future of our families in rural areas.

Sincerely

Jerrell F Gerdes

Jerrell F. Gerdes
Administrator

LETTER FROM DONALD M. GENTRY, M.D.

May 29, 1990

To: Robert J. Kerry
U.S. Senator
2106 1st Ave
Scottsbluff, Nebraska 69361

From: Donald M. Gentry MD
1720 10th Street
Gering, Nebraska 69341

Dear Senator Kerry,

I have been in family practice in Gering, Nebraska for nineteen years and have been happy to practice in a rural setting. Even though I realize I would be able to earn more financially in any urban center, I have been satisfied up to this point and would not like to change where I am practicing now.

I presently practice with two other family practitioners, but did practice with a third. With the loss of that partner, I have become more aware of the difficulties in trying to recruit a new partner in a rural setting. I have known for some time that small towns have had a difficult time recruiting family practitioners. Now that difficulty has reached our practice too. As I review the problem of recruiting in rural areas, I have drawn some conclusions that make it difficult to recruit in rural areas.

As I have talked to some of my friends who are associated with medical schools, it has become apparent that fewer qualified applicants for medical schools are available each year. Therefore, there are fewer physicians being trained each year. Somehow qualified college students must be encouraged to go into medicine.

I think there are many reasons why less people are going into medicine, but one I would like to point out is the general unhappiness of many physicians in practice today. This problem is very complex, and I am not sure can be easily solved. One thing that could be done though is for third party carriers, particularly medicare, to not treat physicians as a bunch of crooks, which I can assure you most of us are not, as if we are trying to steel all there money. Mistakes are made by all humans, and contrary to what some people think, physicians are human too. I think there are kinder ways for third party carriers to point out these mistakes without threatening someone all the time as if you are a common criminal.

Another thing that could be done to make physicians happier is to cut down the frequency the rules and regulations are changed by the third party carriers. It has become impossible, particularly in a busy practice, to keep up with these frequent changes as rapidly as they have occurred. The cost for doctors offices and hospitals to try to keep current on these changes is very significant. The cost of medical care could be decreased somewhat without altering the giving of good medical care, if the regulations were not changed so frequently, and for that matter, if what changes do take place are not so complex that it becomes very difficult to understand.

Another problem that my friends at medical school has pointed out is that fewer medical students are going into family practice. I do not have any answers how to get more students to go into family practice, but somehow the problem must be solved if the problem of rural health care is to be corrected.

A third problem that has been noted is how newly trained family practitioners are not being properly trained to practice in a rural setting. Most family practice residency programs are in urban areas associated with medical schools. They are trained to be only triage doctors, good only if they plan to practice in a urban area. New residency programs must be encourage in rural areas so that the proper training for primary rural health can take place. The newly trained physicians would then not be so fearful in practicing in such a setting.

Through the years, physicians in our area have been conscientious of the cost of health care. We have therefore tried to keep the cost of health care down. This is not the case in many areas of the country. Therefore when it was decided several years ago that medicare charges by physicians would be only partially paid depending on what an individual physician has charged in the past, an area like ours has been penalized for trying to keep those charges down. This inequity of payment has resulted that most rural areas are being paid much less than most urban areas.

Therefore, the salaries offered to new potential candidates looking for areas to practice, cannot be as high in the rural area compared to the urban area. Many of these candidates, after being in training for so many years, are in heavy debt. The amount of salary offered to these candidates is certainly a serious consideration by them when looking for a place to practice. I have letters come across my desk every day that will guarantee a starting salary higher than what I make now. I cannot afford to pay a new partner more than what I make.

The one thing that can be done to alleviate this problem is to equalize the reimbursement for medicare, and medicaid as far as that is concerned, throughout the country. The sooner this is done, the better. I do not think that one can wait four or five years for this to happen. Many areas of rural health care is already in trouble, and they cannot wait that long for changes to occur.

These are some of the concerns I see in rural health care today. I realize the solutions will not be easy, but I think it is important for our citizens who choose to live in a rural community setting are able to get the best medical care available to anyone in this country.

STATEMENT OF ROBERT R. GIBSON

My name is Robert R. Gibson. I am a lawyer in Lincoln, Nebraska. One of my clients is William Anderson, M.D., a physician in Fremont County, Iowa. The testimony that follows pertains to Dr. Anderson's experience at the hands of the health Finance Administration of the United States, and the consequences of this experience for residents of Fremont County.

Dr. Anderson's case is typical of events occurring nationwide. In addition, because his practice is in a rural area, this case illustrates the enormous impact of activities of the Department of Health and Human Services on rural health care delivery

I. THE AFFECTED AREA:

Fremont County, Iowa is a rural area in Southwest Iowa. It embraces several small towns, the largest of which are Hamburg (population 1500) and Sidney (population 1,300). Only three physicians practice in Fremont County, all of them in Hamburg. One of them is Dr. Anderson. Dr. Anderson's formerly extensive practice accounted for more than half of admissions and revenue of Grape Community Hospital in Hamburg.

I. THE AFFECTED PHYSICIAN:

Dr. Anderson, a Mississippi native, was graduated in 1964, from Texas Southern University as a pharmacist. He was a Hospital Pharmacy Resident at Iowa University where he attended Medical School and was graduated in 1973.

Dr. Anderson had a clinical clerkship at the National Institutes of Health in Bethesda, MD. He interned at new England Deaconess Hospital in Boston and served a one (1) year residency there and at Peter Bent Brigham Hospital in Boston. This was followed by a clinical fellowship in medicine for two (2) years at Harvard University, a third year of residency at the Mayo Clinic in Rochester, MN., and a one (1) year fellowship at the University of Iowa Medical School. Dr. Anderson is eligible for specialty certification examination in Internal Medicine.

III. THE HEALTH FINANCE ADMINISTRATION AND PEER REVIEW:

The Health Care Finance Administration (HCFA) is an office in the Department of Health and Human Services and is charged with administration of statutes and regulations pertaining to payments to health care providers under Medicare. HCFA also contracts with private organizations to do "Peer Review" of care delivered by medical professionals. 42 U.S.C. §1320c; 42 C.F.R. §462.1, et seq.

To carry out its charge in Iowa, HCFA has contracted with the Iowa Foundation For Medical Care (IFMC) to conduct "Peer Review" examinations of the care provided by physicians to Medicare patients in Iowa.

The statutes, regulations, and Congressional history of the Peer Review legislation demonstrate clearly that it was Congress' intent to limit unnecessary medical treatments and improve the quality of care given to Medicare patients. To accomplish this, peer review organizations such as IFMC are directed by statute to "apply professionally developed norms of care, diagnosis, and treatment" in reviewing the performance of doctors.

Unfortunately, HCFA apparently has developed a notion that a certain percentage of doctors nationally provide unnecessary services or otherwise show patterns of inappropriate patient care. The bureaucratic fallout from this notion is frightening. The bureaucratic assumption is that removal of at least a given percentage of doctors is the proper measure of the effectiveness of the program.

In May 1986, the United States Inspector General (the legal enforcement officer for peer review organizations) complained in an interview that PROs (peer review organizations) in some states were not sanctioning enough doctors and he speculated that "the answer is to get rid of the PROs that aren't doing their job." A month earlier, the Inspector General in a letter to IFMC about renewal of IFMC's contract had specifically called upon IFMC for more sanctions against providers. This letter went on to inform IFMC that "your record in this area will, of course, be part of the PRO evaluation process presently being conducted by HCFA."

The IFMC is a profitable venture. In addition, there is a predictable desire on the part of physicians to provide their own peer review, rather than surrender this awesome authority to strangers in or out of government. Obviously, there is strong incentive for IFMC to preserve its contract for Iowa peer review, even if that which is required is unseemly or unsavory. These self-preservation factors were tinder for the fire of Inquisition. The "sanctions quota" spark supplied by the Inspector General was more than ample for ignition

One obvious ramification of this volatile procedure for individual physicians is that those of their number who are socially most expendable might be sacrificed, without regard to merit, in order to appease the appetite of the Inspector General for more sanctions.

For the community at large, the ramifications are even more sinister. These ramifications are as follows:

A. That physicians are driven from practice in areas that can least afford to lose practitioners;

B. That this loss is beyond the control or desire of physicians or patients; and

C. That the Congressional intent to promote and improve the quality of health care is alchemically subverted into the elimination of health care.

IV. THE CASE OF DR. ANDERSON:

The experience of Dr. Anderson at the hands of IFMC and the Inspector General illustrates the above. At the time Dr. Anderson began to be the focus of an IFMC inquiry, he was one of a team of successful and prosperous black physicians practicing in Burlington, Iowa, a predominantly white community of 30,000 in Southeast Iowa. This does not prove that Dr. Anderson's ensuing experience was necessarily the result of racial iniquity. On the other hand, he most certainly was not in the cultural mainstream of his professional peers. In this respect he was "expendable".

The IFMC selected for its focus Dr. Anderson's care of four Medicare patients as follows:

A. An 87 year old man who presented at the emergency room with cardiac and respiratory failure;

B. An 83 year old terminal cancer patient;

C. A 65 year old stroke victim; and

D. A 71 year old stroke victim.

In my opinion, the IFMC's criticism of Dr. Anderson in these cases was procedurally unfair and in many respects logically unsound. However, it is not my intent to try his case here in detail, inasmuch as it is the subject of pending legal proceedings. Suffice it to say, that IFMC has brought about the disqualification of Dr. Anderson to receive any Medicare reimbursements for five (5) years, and that this disqualification has effectively eliminated one third of Fremont County's medical resources. It has also jeopardized the hospital in Hamburg.

V. THE PROBLEMS DELINEATED:

It is my purpose to call to the Committee's attention several problems arising in cases like Dr. Anderson's case and to propose constructive considerations for their solution. The problems are as follows:

A. The statutory and regulatory schemes governing the functions of PROs lack sufficient checks and balances to preclude arbitrary administration;

B. Legal redress for insufficiencies of administration is tortuously slow and totally inadequate to prevent irreparable destruction of a sanctioned physician's career;

C. The performance of physicians is measured by statutory standards so ineffable as to preclude rational external evaluation and review;

D. The practical effect of this regulatory scheme is to transfer from state licensing authorities to private, profit-motivated organizations the power to censure and discipline physicians.

Congress intended to improve rather than remove medical care. Accordingly, the statutes and regulations encourage "corrective action" in the case of physicians whose quality of care is found wanting. This might include specific teaching by specialists in the peer review process, or continuing medical education, or other similar measures. Severe discipline such as the sanction imposed upon Dr. Anderson supposedly is a last resort, to be inflicted only where there is established unequivocally a pattern of "gross and flagrant" violation of an appropriate standard of care. Even then, such a sanction is supposed by statute to be reserved for those "gross and flagrant" cases in which the practitioner is found to be "unwilling or unable to comply" with professionally recognized standards of care.

Unfortunately for us all, there is no codified "standard of care" nor is such a standard even coherently articulable in many cases. The consequence is that the "standard of care" with which Dr. Anderson is expected to comply is that standard pronounced retroactively by IFMC. Of course, IFMC members have had the benefits of hindsight, consultation, and time for research before promulgating these standards. More importantly, these arbitrary standards are developed and applied by different IFMC members in each case and these "standards: may or may not be consistent. Equally problematic is the determination of when a physician is unwilling or unable to comply with standards of care. This is a determination that does not solely depend on medical expertise, but involves subjective judgments of character vulnerable to manipulative abuse, or outright caprice.

Finally, the "standards" of professional care are also necessarily subjective and vulnerable to the kind of criticism currently being leveled against "adjudication by expert witnesses" in our state and federal courts. In short, such "standards" cannot possibly meet ordinary standards of fundamental fairness, nor do they reasonably assure the achievement of quality health care.

Needless to say, it is difficult even for an unbiased observer to assess a physician's willingness or ability to comply with a standard and especially one which is indefinable. Presumably, an individual who is discernibly impaired by organic dysfunction or severe mental debilitation might fail to meet the test. But what of practitioners like Dr. Anderson whose prestigious academic and practical achievements suggest a high degree of competency? There is in his case no hint of physical or mental impairment. Instead, IFMC reviewers which had interviewed Dr. Anderson about his cases in a demonstrably hostile adversary proceeding, decided he was recalcitrant because of the following:

A. They detected sarcasm in his declarations of intent to follow their direction; and

B. They were not convinced by his exposition of literature he cited in support of his care decisions.

IFMC translated these aspects of Dr. Anderson's presentation during the Inquisition as "(1) a fundamental lack of comprehension of important medical facts and principles . . .; (2) illogical thought processes . . .; and (3) inappropriate attitudes . . .." It must be obvious without debate that such generic findings could well be bootstrapping by the IFMC for the sole purpose of justifying a sanction, rather that a detached, objective assessment.

VI. THE CONSEQUENCES:

After IFMC's preliminary report, it published prematurely and against specific regulation IFMC's findings and recommendations. The Burlington hospital thereupon withdrew staff privileges and in effect rendered Dr. Anderson's practice in that rural community impossible. Dr. Anderson relocated in Tabor, Iowa in Fremont County to replace a retiring physician. Further public disclosure of the IFMC rulings caused Dr. Anderson's new partners to terminate his association (closing the Tabor, Iowa clinic), and they published an advertisement stating Dr. Anderson's trouble with the authorities.

Dr. Anderson then returned to Mississippi to pursue a medical teaching position but the Mississippi State Board of

Licensure declined to issue a license to practice pending the final outcome of the IFMC inquiry.

Dr. Anderson returned to Hamburg, opening his own office. Then the IFMC sanction officially took effect, barring Medicare payments. This eliminated about 60% of his practice. In April of this year, Dr. Anderson was informed that Blue Cross and Blue Shield of Iowa terminated his "select physician" contract retroactive to the date the IFMC sanction took effect. IFMC now has informed the Iowa Board of Health that IFMC is reviewing a large number of additional cases handled by Dr. Anderson and has encouraged the State Board to seek Dr. Anderson's license revocation.

This travail has proceeded apace nothwithstanding Dr. Anderson's appeal from the IFMC actions. The appeals board may or may not grant oral argument, and in any case the appeal will not be taken up for at least a year. In the meantime, Dr. Anderson is reduced to a practice with uninsured and non-Medicare patients. All of those persons insured by Blue Cross or Medicare are forced to choose between their benefits and their physician.

Recently, a 41 year old man with a heart attack went to the Tabor, Iowa office of Dr. Anderson for help. He found it unmanned due to Dr. Anderson's involuntary removal. The rescue squad was called but during the ensuing 20-plus mile transportation to a hospital, the patient died. No closer medical assistance was available.

VII. POSSIBLE SOLUTIONS:

A. Provide by statute or regulation for judicial discretion to impose upon PROs sanctions, such as payment of expenses and attorney fees incurred by a practitioner in the event PRO actions are found to be frivolous, unwarranted, or in bad faith. Precedent for this approach may be found in Rule 11 of the Federal Rules of Civil Procedure applicable in United States District Courts.

B. Prohibit the use for any federal or PRO personnel of any standard of pay that depends directly or indirectly on the number of sanctions imposed.

C. Grant to United States District Courts specific jurisdiction to enjoin or otherwise interdict publication or enforcement of sanctions in cases in which the practitioners can meet traditional requirements for injunctive relief.

D. Prohibit divulgence of patient records, practitioner records, and administrative opinions or findings of fact to state regulatory authorities, excepting those legal opinions and decisions which become public records by virtue of their issuance by governmental judicial officers or administrative tribunals.

E. Provide for priority or expedited judicial and appellate review of PRO sanctions.

F. Limit review of patient care to those cases called to the attention of a PRO by specific complaint of a licensed health care practitioner, a patient, or a member of a patient's family.

G. Declare unequivocally that the burden of proof is upon the PRO in all stages of proceedings and define the standard of proof (e.g., "beyond a reasonable doubt").

H. Provide for the presentation of PRO "expert" reviews of patient care by health care professionals who do not serve the peer review organization as a member of any reviewing panel or board. In short, provide that a PRO panel member may not serve as prosecutor in some cases and as judge in others.

I. Provide subpoena power to accused practitioners to compel the testimony of professionals in their behalf.

J. Medical records traditionally are regarded as privileged information. Present statutes authorize wholesale governmental intrusion upon this privilege without the consent of patients. This scheme is constitutionally suspect. Access to records should be limited to those records obtained with the voluntary consent of the patients.

K. Limit the imposition of prospective sanctions to cases in which the practitioner's license to practice has been limited or suspended by state authority.

L. Limit the imposition of the sanction of prospective disqualification to those cases in which (1) a practitioner has been found guilty of "gross and flagrant" violations in a specified number of cases within a specified period of time; or (2) the practitioner is prevented by manifest physical or mental impairment or legal disability from meeting the standards for licensure within his or her state; or (3) the practitioner's violation of standards of care is willful, wanton, or in reckless disregard of the well-being of the patient.

N. Provide that a PRO may not review the care provided by a practitioner during the pendency of a previously initiated sanction proceeding or in more than one proceeding within a specified period of time.

O. Provide that a sanctioned practitioner may apply for modification or reduction of his sanction upon a showing of merit.

P. Prohibit consideration of the number of sanctions imposed as a factor in qualification of a PRO for granting or renewal of a contract, (i.e., eliminate the quota system).

Q. Provide that no sanctions may be imposed upon a practitioner or made public until administrative appeals have been finally determined.

In my view, most or all of the original Congressional objectives could be accomplished by a scheme which simply permits disallowance of payment for a service found to have been unnecessary or improper. The business of removing inept physicians should be left to the states or at least dealt with by an administrative structure based on traditional licensure and revocation standards. Alternatively, prospective Medicare disqualification should be limited to cases in which the practitioner has done acts of the kind which would support revocation of the practitioner's license.

This approach would honor both the public's need to be protected and the public's need to preserve scarce medical resources from arbitrary elimination on the alter of bureaucratic expediency.

STATEMENT OF CAROL GIFFORD

I am a 32 year old farm wife with two children. We live in rural western Nebraska. My husband and I farm about 350 acres. I would like to address some of my concerns on rural health care. I serve on a national Rural Health and Safety Advisory Committee and we have some concerns that we have discussed also.

First off, we in rural areas are very concerned about the high cost of health care and insurance. Being considered a small business we must purchase our own health insurance which is very costly and it is something we can't do without. A key point that needs to be addressed is that we, as individual purchasers, should be allowed the same tax advantage as employer-provided health insurance.

Another key issue is to eliminate waste and control rising health care costs. Following along the lines of the tax advantage is the fact that many individual insurance holders pay for medical bills out of their pocket. Many hospitals do not quote a "package" price to individual insurance holders as they would to large insurers.

It seems that now we are almost "reactive" instead of "proactive" in the next idea. We need incentives for post-retirement health care. Whether these be in the form of tax incentives, Medical IRA or other tax credits this issue needs to be addressed.

Eliminating waste in Medicare would be a huge savings for the American public. Every year we see more and more cost being added to this program. One possible way is to encourage private insurers to repackage Medicare benefits and create policies for Medicare beneficiaries. Also establishing a tax incentive for the elderly to establish Medisave accounts for small medical bills.

Another aspect that needs looked into is the fact that most health care regulations and funding are based on the assumption that people go to doctors and large hospitals. Living in rural areas this is not always possible. We need alternative delivery systems for health care in rural areas. Small rural hospitals may need to operate more like large clinics that provide limited hospital services. If these areas are recognized and dealt with it would give people in rural areas more flexibility in responding to their health care needs while lowering costs for most basic care.

I see the struggle every day within our society concerning rural health care costs and dilemma we are facing. We need to work on solutions now and not keep surfacing the problems. We know several of the key areas that need addressed we now need to be addressing the solutions.

LETTER FROM HARRIET M. GODING

June 3, 1990

MEMO TO: The Honorable Robert Kerrey

FROM: Harriet M. Goding
Box 261
Potter, NE 69156

I have several questions that seem pertinent to the issues of rural health care.

1. What legal right does Medicare have to pay less to physicians in a less populated area than it does to those in urban areas? Is it written into the law?

2. Would it help to request a lowering of our Medicare Insurance premiums in the less densely populated areas?

I think that I have a perfect example of the misuse of my medical premiums in a recent medical problem.

Both of the following physicians are Urology Board Certified:

Sun City, Arizona	Billed	Approved
20 minute office visit	$ 82.41	$70.70
Scottsbluff, NE		
Out-patient Hospital Procedure		
Cycstoscopic Exam of Bladder		
2 hours time	167.75	83.20

I am very interested in and concerned about the problems of rural health care, and would like to do whatever I can to be of help.

Sincerely,

Harriet M Goding

HEALTH CARE FINANCING ADMINISTRATION
May 15, 1990

Need help? Contact :
Medicare
Blue Cross and Blue Shield of Kansas, Inc.
1133 Topeka Blvd
P.O. Box 3512
Topeka, Kansas 66601-3512
Provider Telephone No. 1-800-633-1003
Beneficiary Toll Free 1-800-633-1113
Toll Number 1-913-291-7000

HARRIET M. GODING
BX 261
POTTER NE 69156

PARTICIPATING DOCTORS AND SUPPLIERS ALWAYS ACCEPT ASSIGNMENT OF MEDICARE CLAIMS. SEE THE BACK OF THIS NOTICE FOR AN EXPLANATION OF ASSIGNMENT. WRITE OR CALL US FOR THE NAME OF A PARTICIPATING DOCTOR OR SUPPLIER OR FOR A FREE LIST OF PARTICIPATING DOCTORS AND SUPPLIERS.

Your doctor or supplier did not accept assignment of your claim(s) totalling $ 167.75. (See Item 4 on back).

X		BILLED	APPROVED
DR ENGELBART			
1 Amb. Surgery	Apr 20,1990	$ 167.75	$ 83.20

Approved amount limited by item 5c on back.

Total approved amount	$ 83.20
Medicare payment (80 % of the approved amount)	$ 66.56

Under the current law, we have reduced your Medicare payment by 1.4 percent for services you received between April 1, 1990 and September 1990.

You are responsible for a total of $ 102.12, the difference between the Billed amount and the Medicare payment. You could have avoided paying $ 84.55, the difference between the Billed and Approved amounts, if the claim had been assigned.
We are paying a total of $ 65.63 to you on the attached check. Please detach and cash it as soon as possible. If you have other insurance, it may help with the part Medicare did not pay.

(You have met the deductible for 1990)

IMPORTANT: If you do not agree with the amounts approved you may ask for a review. To do this you must write to us before Nov 15,1990 . (See item 1 on the back.)

DO YOU HAVE A QUESTION ABOUT THIS NOTICE? If you believe Medicare paid for a service you did not receive, or there is an error, contact us immediately. Always give us the:

Medicare Claim No.	Claim Control No.	
471-12-8806-A	05-90-115-50584-0	(23018)

HEALTH CARE FINANCING ADMINISTRATION

To FRA 5-26-90

AZ-U-006856

AETNA MEDICARE
10000 N 31ST AVE
P.O. BOX 37200
PHOENIX, AZ 85069

APRIL 05, 1990

HAVE MEDICARE QUESTIONS? CONTACT:
(602) 861-1968 OR TOLL
FREE 1-800-352-0411.

HARRIETA M GODING
9733 N 105TH DR
SUN CITY AZ 85351-4708

YOUR HEALTH INSURANCE CLAIM NUMBER

471-12-8806A

PARTICIPATING DOCTORS AND SUPPLIERS ALWAYS ACCEPT ASSIGNMENT OF MEDICARE CLAIMS. SEE THE BACK OF THIS NOTICE FOR AN EXPLANATION OF ASSIGNMENT. WRITE OR CALL US FOR THE NAME OF A PARTICIPATING DOCTOR OR SUPPLIER OR FOR A FREE LIST OF PARTICIPATING DOCTORS AND SUPPLIERS.

YOUR DOCTOR OR SUPPLIER DID NOT ACCEPT ASSIGNMENT OF YOUR CLAIM(S) TOTALLING $ 132.01. (SEE ITEM 4 ON BACK).

		BILLED	APPROVE
FAYES CUSTOM			
1-SUPPLY	MAR 1,1990	$ 24.00	$ 24.0
1-SUPPLY APPROVED AMOUNT LIMITED BY ITEM 5C ON BACK.	MAR 1,1990	$ 25.60	$ 24.
DR P PAPOFF			
1-CONSULTATION APPROVED AMOUNT LIMITED BY ITEM 5C ON BACK.	MAR 12,1990	[illegible]	[illegible]

TOTAL APPROVED AMOUNT	$ 119.2
MINUS YOUR DEDUCTIBLE REMAINING FOR 1990	$ 75.0
AMOUNT REMAINING AFTER SUBTRACTING DEDUCTIBLE AMOUNT	$ 44.2
MEDICARE PAYMENT (80 PERCENT OF THE APPROVED AMOUNT REMAINING)	$ 35.
MEDICARE PAYMENT AFTER 2.092% GRAMM-RUDMAN REDUCTION	$ 34.

UNDER THE CURRENT LAW, WE HAVE REDUCED YOUR MEDICARE PAYMENT BY 2.092 PERCENT FOR SERVICES YOU RECEIVED BETWEEN OCTOBER 17, 1989 AND MARCH 31, 1990.

LETTER FROM DAVID C. IMES, M.D.

David C. Imes, M.D.
1275 Sage
Gering, Nebraska 69341

Senator Bob Kerrey
302 Hart Office Bldg.
Washington, D.C. 20510-2703

RE: Senate Subcommittee hearing.

Dear Senator Kerrey:

I appreciate the effort you are making to attempt to understand some of the problems that rural Nebraska patients and physicians have concerning health care. I have been in family practice in a small group in Gering for 14 years. We had a 5-man group until 2 years ago when the newest partner elected to move to Wisconsin. One of the reasons he gave for leaving was financial. He was moving to an area of very low welfare and Medicare patient populations and his starting salary in a new group was $10,000 a year more than we, ourselves, were making. This brings up one of the obvious problems with the present system. If you have a relatively low Medicare-welfare patient population then 60% reimbursement for office services is more tolerable. In area where we have 30-50% Medicare and welfare combined the overall income to the clinic is decreased by about 15-20%.

In our clinic we average 20-22% of the gross income in payment for office secretarial and nursing staff. Our consultants say this is average for a family practice, however, we feel we are not able to pay our office staff the salaries that they need. In our area one of the major employers is the health care industry. Not only are the physician's take-home pay lower but everyone else in the system has the same problem. If we were to receive reimbursement that was similar to the cities in metropolitan areas of the country, then we would be able to recruit not only more primary care doctors to a rural setting, but we would also be able to pay a more reasonable wage to all of the other workers in the health care system.

I know there is no easy answer to this payment problem, however it seems to me that the large differentials between city and country and coastal and rural areas essentially needs to be eliminated if we are going to spread out the physician and nursing populations.

Another problem for the small office (and it certainly is a problem in our office) is that we have really no way to fully understand or deal with the Medicare rules that periodically come in the mail. When we call for clarification we frequently get different answers from different people and when we try to interpret these regulations ourselves sometimes we are mistaken. When this happens we not infrequently get letters from the government claiming that for fraudulent claims we may be assessed fines or kicked out of the Medicare system. They also send letters to the patients at times saying the therapy or treatments were inappropriate and the patient should be paid back. We have no control over when patients come to the office in the primary care setting. It is not possible for a receptionist to decide if a patient really needs to come to our office. If one worked for a larger clinic or hospital, then someone else is available to help interpret the regulations or find out what they really mean. Because of this, it is fairly difficult to practice on your own or in a small group in a rural setting. Although I have been in practice for 14 years and I like practicing in Gering and I really like living in Gering, if I were starting now I would be looking for a family practice group that was associated with a large hospital or multispeciality clinic and would not be looking to practice in a rural setting. It is really quite frustrating to do what you think you morally and ethically need to do and then have letters from the government not only accuse you of practicing or billing fraudulently, but also sending letters to your patients saying that the care they received was inappropriate.

In whatever system the government eventually decides is good for medical care for patients and is affordable to the government there are several changes that need to be made. One of the changes is that the government should not be attempting to break down the trust patients and physicians develop because when the patient then develops a serious problem they no longer believe their physician and end up doctor shopping and seeing 2 or 3 physicians for the same problem. Patients also need to have some financial responsibility for their health care. If they do not, their number of office visits not only increase but their demands for services for such items as routine x-rays and blood work and electrocardiographs also significantly increase. With the insurance programs and prescription cards now available I have patient's requesting 3 or 6 months worth of medication so they won't have to pay the $6.00 refill fee when they are asking for a medication that will cost $200.00 or $300.00 and they may not be on it that long.

Physicians have to be responsible for providing good health care but patients have to be, at least in part, responsible for the cost of that care or their demands become exorbitant. I hope that something can be done in the near future to make the practice of medicine in the rural areas of the country more acceptable to all health care providers because it is rapidly becoming difficult for patients to find doctors in our community. If you have talked to consumers you will find that that is one of the problems locally and our problem is not nearly as severe as it is some of the surrounding smaller towns. I do think we would be successful in making primary care more available if we were on equal footing with the rest of the country.

Sincerely,

DAVID C. IMES, M.D.

STATEMENT OF W.A. JOLLY

Good morning, Senator Kerrey.

My name is William Jolly. I live at 316 West 20th Street in Scottsbluff, Nebraska. My phone number is 632-3024 and I am an admirer of yours. I went to the meeting on Sunday and I was very disappointed in the canned pitches by the professionals and the general public were not given much of an opportunity to offer any suggestions. In my viewpoint it was a negative program that was presented and I may have a few suggestions that may be of help to solve some of the problems. There are just too many and President Bush keeps painting such a rosy picture that I don't think the general public realize what a predicament the health care problem is in the states.

I am formerly from Saskatchewan, Canada where I live for over thirty years and I moved to the states with my wife because her family all lived down here. But now they've all died. My wife died two years ago from Alzheimer's Disease and I took care of her at home for three years and had her in a nursing home in Brush, Colorado for four years. Two of them were ones that I paid over $1,600 a month plus about $200 for medicine and the other two years were under Medicaid which medicine was cut back to about $12.00 a month. So there is quite a big discrepancy right there. I never could see the policy of giving all these medications, the expense of some of them were $40-$50 a bottle. I think most of the medication was given just to help the staff, to keep my wife tranquilized -- which she was a good part of the time. Either that or tied down because she liked to roam and they couldn't have that. Of course, she did break her hip and broke her nose one time when she fell, so Alzheimer's is a disease where they almost need one on one care.

I am not criticizing you at all for these problems. It is just something that might not be known by the general public. The thing is that there is a terrific waste, I think, in Medicare and I am on my fourth pacemaker so I know what the story is on that end. The pacemaker alone costs $4,000 and the actual cost, I think, should be closer to $200. I think there is something wrong there. For outpatients -- you go in the morning about 5:00 and you get out about noon and your bill is around $12,000. Just for a pacemaker. The first one I had I had to go to Denver, they had to fly me to Denver, I was there for about ten days. I went through several different procedures there -- medical procedures -- which all added up to the cost and at that time I wasn't on Medicare. I am 77 now so that was several years when I was in my early sixties. It has come a long way since then, but at that time they didn't implant pacemakers in Scottsbluff, you had to go Denver. But now they can do it here just as I mentioned, on an outpatient arrangement, but they are still very expenses. But my body rejected two of them so I am on my fourth and about due for another one. I just can't afford to go through that again. That's another problem. You have Medicare which pays 80 percent of what they recommend. But the doctors -- several of them -- just double the amount that Medicare recommends. So if it is a $400 operation which I need for prostrate, they make it $800. Then Medicare only pays 80 percent of the $400 and my supplementary insurance picks up 20 percent which is Mutual of Omaha that I have, so that I am still left holding the bag for quite a sum. Besides that you have to pay the first $75 before you can even have any reimbursement and the office call is around $20 so you have to pay all of that because until such time as you pay that $75, you don't get any reimbursement. As a result, I've just managed to get by without having the operation. I just believe that there are many people in the same predicament.\

The point I was trying to get around to is that in Canada, I was there when they first started the mandatory hospitalization.

That met with a lot of opposition from the medical profession at the start. So they put in hospitalization first. That was the first province that had it. It was a very small amount that each person contributed. For a year it didn't amount to very much but you didn't have any worries about hospitalization. The only thing is is that there was an awful lot of people went to the hospital and they had to build other hospitals to accommodate them. The population, when it first started, was about 40,0000 in Regima and it quickly increased to where it is now -- about 180,000. It had quite a magnetic effect on bringing people into the Province and as a result a lot of new industries started up and they had a theory up there at work makes work. A lot of people were put to work as an outcome of having hospitalization -- free hospitalization -- so you're taken care from the cradle to the grave under this program. Even office calls were covered -- that was under group doctor insurance plan we had with the firm that I worked for -- the city light and power company -- and we were completely covered as far as doctors went, even office calls under that plan.

It sure relieved a lot of stress and it gave you money for other things because just one year's payment for doctors and hospitals wouldn't amount to what one day in the hospital amounts to here. So you can see the difference in the program and they do have wonderful doctors and care up there. At first the doctors objected to the mandatory doctors' program which they later brought in so a lot of doctors left and came down to the states. The Board turned around and recruited them from here -- from Yugoslavia, from Germany -- from all other European countries. Actually I had a service disability. I had cartridge in both knees removed -- one was by a military doctor and the other later on was from a Czech woman and you can't tell the difference. They are actually far better educated in some of those European countries than they are here in the states. I know I have a friend up in Canada whose father was a doctor and he started out to be a doctor but he couldn't pass the exams. So here came down here and had his license in no time. I think the educational standard up there is much higher than what it is down here.

They have an educational sales tax which was the first tax they put on up in Canada and that was put on just around the Depression time. I went all through the Depression up there so I am familiar with all that, too. It can be done, you know. Of course, the way the government looks at it up there is that natural resources, that's water, timber, oil, and gas -- any natural resources -- belongs to the people. So they, in turn, tax those natural resources which goes towards the payment of the medical program for the people. It takes about a year before you can qualify for the program. In other words, you just can't go in there and start to received the benefits. You have to be a resident for a year. So that they do disclude a lot of opportunists from taking advantage.

Another point they have -- I have another friend who went to Hawaii and he had a heart attack when he was there and he was in the hospital for over a week. When he got his bill it was for $10. So they do have an arrangement with some of the states where they honor the Canadian medical program. I am not sure which states honor it, but it is something that could be looked into. Probably states close to the border. But it is a matter of tourism. My sister would never come down to visit us because she wasn't too well and she said she couldn't afford to have the medical care down here that she got up there so she wouldn't come to visit. I had to go up there to visit. She now is in the hospital with Alzheimer's disease up there and all her payments are is what her old age pension is which is around $600 up there. That is turned into the government and it is all taken care of. I've been to visit her a couple of times and she is getting marvelous care. They have quite a large of building, they have day care too as well. But they have a large hospital building and it's divided into different floors as the disease progresses they go to a different floor level. It is a disease -- and I am very familiar with it -- they just deteriorate right down to back to childhood and they just need so much care that it can't be done at home. They have to be in a nursing home. She is making very good progress -- much better than my wife did at Brush, Colorado. I had to take her to Brush because the nursing home that I put her in here just couldn't handle her at all. They didn't have the help, for one thing, they just confined her to one little room. It just wasn't very good.

That is something else that is needed -- an Alzheimer's facility in this area. There are a good many patients who are not getting as good a care as they could in a facility that is strictly for Alzheimer's. I belong to an Alzheimer's support group which I go to once a month and have been for a good many years now. It is something you really need to try to reshape your life. Of course, it is something that you never get over and as a result I have to take a kind of a sleeping pill every night in order to be able to sleep, otherwise I would stay awake most of the night. But that's my problem. I mean other people have different problems with the disease. It does effect the whole family. It is not just the patient. The caregivers are really the ones that suffer the most. Because the patient really doesn't know what's going on a lot of the time.

I've outlined several problems but there still is another one and that is we are more or less getting into free trade with Canada and I think that also should include the health transferring from one country to the other. For example, my son who lives in Denver, his wife was on a dialysis machine and he went up to visit my sister in British Columbia who was observing her 50th anniversary. While they were up there, his wife had to have a dialysis treatment, actually she had to have two of them. They were charged

$600 each time although she was covered with Medicare. That's a discrepancy that could be corrected too if we had free trade. How are you going to get tourists to come back and forth when you can't assure them that they're going to be as well in one country as they are in another. Those are a few suggestions. I was very disappointed as I mentioned. It was such a canned program that they held and the general public was not allowed to participate.

I did talk to Senator Dashchle for a few minutes but it was not a very appropriate place to talk with him. He seemed to be interested in what I had to say. I didn't say very much. I thought it would probably be better to contact you. I did ask Senator Dashchle if they would consider sending a panel up to Saskatchewan to look into their health programs. I mentioned to him they've never had any charge for cancer patients. My mother was on cobalt for years and years and it never cost her a cent. So that is another big problem is cancer. It is all taken care of. They never have to worry about that. He said there had been a panel sent up to Canada. Saskatchewan is about the same size as Nebraska so it would be a better province to correspond with. I have a brother who is a banker -- he's retired now -- he would be glad to help you get any statistics or information that you might want. He lives in Regina and he's in the phone book under Douglas D. Jolly so if you should ever happen to get up there, Senator, look him up and tell him that I mentioned this subject.

I have been away from there -- I've lived here now over 30 years so I've lived in both Canada and the United States for about the same length of time so I am familiar with both of their health problems. I can see the advantages and, of course, there's disadvantages too. But I thought you should get public opinion about some of the problems we run into. We run into plenty of them into Medicare. That all adds to stress because Blue Cross-Blue Shield is the primary medicare payer and they send you a bill all the time -- I mean the hospital keeps sending you bills but until such time as Blue Cross sends you a bill, you supplementary insurance won't pay. So it's frustrating for someone that likes to keep their bills paid up, very frustrating. I can understand Cary Nells' problems there with all that paperwork with Medicaid -- that is a headache in itself, filling out that form. I guess bureaucracy needs all that paperwork in order to function, but there should be an easier way. I think that if the states could check into some of the other countries that have mandatory health care programs, they might be able to come up with something much better than what we have.

This is a broke proposition no matter how you look at it. It's getting worse, it seems, all the time. There are so many people that don't have insurance at all. I have been told that some hospitals won't allow you to come in unless you have some form of payment. That is another problem, too. I have another suggestion, but I can't think of it now. I'll shut this office for a second --

I think I remember what I was going to say. I'm a Canadian veteran -- actually I was in the service in 1939 to 1946 in different branches. From my disability pension I get a small check each month. As far a receiving medical care from being a Canadian veteran -- I don't qualify. It is another problem between Canada and the United States on freedoms. We were allies and yet as far as getting medical care, we don't get it here unless something can be done to change it. Actually I have thought some about returning to Canada since my wife and all her family have passed away. I do have all my children and their families living here. But they're all grown and they have their own families to support. I have brothers and sisters in Canada and I have thought some about trying to sell my house. But in this area you almost have to auction it in order to get rid of it, so it might come to that point that I have to get rid of the house and move back up to Canada. I would receive a lot more benefits then what I would received here. That's my problem.

I would appreciate any comments or solutions you might have to some of the problems I have mentioned and let me know. I have given my address and phone number and if you need any more information from me, I would be glad to contact you or your office or anyone you suggest because I have this unique experience of having been under the Canadian medical program and under the American program. I can differentiate between them and I know about the reciprocity treaty between some states and Canada which I think would be beneficial down here.

Of course, now, in Canada when they started their mandatory program, they were the first ones to start it and that to me is about the only way it will go is for one state at a time. I think Massachusetts has it now, but Nebraska or South Dakota could put it in without too much trouble at all and it would add to the population, it would create jobs, it would be far more beneficial than the system we're working under now in my opinion. It is something to consider anyway.

Thank you for your time in listening to this tape and take it at it's worth.

LETTER FROM PHILLIP JOHANNES, JR.

Sen. J. James Exon
2106 First Ave.
Scottsbluff, NE. 69361

90 MAY 31 AM 10: 23

May 30, 1990

Re: Nationwide Omnibus Budget Reconciliation Act of 1987

This plan which mandates all nursing homes be reclassified as Skilled Nursing Facilities as of October 1, 1990 will force Western Nebraska Nursing Home at Mitchell, Nebraska, along with hundreds of others nationwide, to increase by several hundred dollars a month the cost for care for my mother-in-law. This projected increase will raise the cost for her care by over 60% over what it was just three years ago when she went there.

She saved as much as possible over the years and thought she had enough to last the rest of her days here in this life. I now project with the increases she will probably have enough only for about three more years. It is tragic that our elderly who have conscientiously saved must now have it taken away from them by bureacratics in Washington.

We are very satisfied with the care she is now receiving at the nursing home. It is very clean, the food is good, the employees very expert in their care and there are many activities to keep the guests busy. If she were in a poorly run home there are now laws and regulations on the books to insure the conditions are changed or the home would be closed.

Our request to you is you use your influence to change the act so as to keep the cost of nursing homes at a point where the vast middle class can afford to use them.

Thank you for your time.

best regards,

Phillip Johannes Jr.

LETTER FROM DON KESSEN, ADMINISTRATOR, KIMBALL COUNTY HOSPITAL

Western Nebraska Regional Office
2106 1st Avenue
Scottsbluff, NE 69361

May 22, 1990

Dear Senators Kerrey and Daschle:

In response to your request for written testimony on how Nebraska is addressing rural health care, I, along with many others in rural settings, do not believe that any one knows there is a rural Nebraska. The rural hospitals, and other health related fields of Nebraska, are being slowly but surely wiped out of the picture. Believe me, that will definitely effect the quality of health care to Nebraskans. The rural hospitals are capable of doing a great deal of treatments, surgery, and at the very least, good acute care. These same procedures done at an urban setting would be allowed more payment, using the same amount of personnel, or even less. They keep picking away at the rural hospitals reimbursement for Medicare and Medicaid even though they have more percent of the two per capita than urban settings.

Our Federal and State people keep promising us more help to come in a couple of years. By that time, it will be too late for a lot of us in the rural setting!

I think that we are at a point where something with a better reimbursement ratio be put into action now, not later!!

The above is also part of the reasons a rural hospital can not convince Family Practice and/or General Practice Physicians into our areas, along with more hours at work, or on call; less time allowed for their families, etc.; and last but not least, less payments for Medicare and Medicaid; and more and more restrictions each year. I think it is time that rural hospitals and doctors be considered a valuable part of health care in Nebraska.

Sincerely,

Don Kessen, Administrator
KIMBALL COUNTY HOSPITAL
505 South Burg
Kimball, NE 69145

DK/ceg

LETTER FROM LOUIS E. KLEAGER, M.D.

Dear Senator Kerry,

Thank you for holding a hearing in Scottsbluff on 6/3/90 for investigating the "Future of Rural Health." As an Ear, Nose, and Throat specialist, I would like to address the sometimes forgotten problems that our patients are having with the current, sharply unbalanced Medicare system of reimbursement.

At this time, our Medicare eligible citizens in Western Nebraska are being reimbursed far less than most Medicare citizens elsewhere in the United States for the same physician services. As an example, Dr. Kent Myers, who recently left Morrill, Ne., as its only physician, to move to Arizona to resume the same type of practice, told me that in Morrill, Ne. he was allowed by Medicare to charge $21.08 for an extended office visit (#90060.) Where he is now practicing in Arizona, he is allowed to charge $37.50. The fact which I wish to emphasize is that in Morrill his Medicare patients had to pay $7.00 of the $21.08, whereas in Arizona, his patients only have to pay $2.00 of the $37.50 charge. This is a shameful discrepancy, one which needs to be immediately changed by the Federal Government. I would guess that the Western Nebraska economy is no stronger, and probably weaker than the Arizona economy, yet our citizens are being charged much more by Medicare. Medicare strictly controls what physicians may charge and what patients must pay, and is therefore, totally responsible for this problem. This extra charge to our patients amounts to an extra tax. We call it a "sickness tax." There is no fair reason why this payment should not be equal for all Medicare eligible citizens in the United States. Quite clearlly, the rural Medicare patient is being discriminated against by the Fedral Government.

The physicians and patients in rural America have read quite a bit, and heard a lot of verbage from our government and our representatives about recognizing the unfairness of the Medicare system toward rural patients. However, we have not yet seen any action come from Washington that has substantially changed this problem.

I would recommend that Congress pass legislation that would, this year, equalize the payment a Medicare patient is required to make for his or her care reguardless of their geographic location. Thankyou for listening to this complaint about one of the many problems with the Medicare system.

Sincerely,

Louis E. Kleager, M.D.

LETTER FROM CARMEN KLEAGER, R.N., ADMINISTRATIVE ASSISTANT, FALCO

To the Honorable Bob Kerrey and the Honorable Tom Daschle
and Members of the United States Senate:

The health-care issue is a major concern of many Americans. The fact that 34 to 40 million Americans have no health-care coverage is disconcerting. And, with the cost of health care rising and insurance premiums increasing at a rate of an average of 20% each year, the number of persons uncovered will continue to increase. As an example, employers will not be able to offer a group coverage insurance plan as they have done in the past, because of the increasing cost of these plans. Therefore, employees will be left to obtain individual coverage; many will be unable to afford the insurance premiums necessary to obtain adequate coverage. Also, many senior citizens who are on fixed incomes are experiencing increases in the premiums of the Medicare supplemental policies necessary to bridge the gap between the amount of the fee and the amount that Medicare pays for the service. Supplemental coverage may not be affordable for them, and they, too, will be unable to meet the costs of their health care. Also, a large group of Americans have an income that is enough to prevent them from being eligible for Medicaid, but is not enough to allow them to afford health insurance. They, too, are unable to meet the costs of their health-care needs. As a father stated to me, "I have to choose between groceries and health insurance premiums for my family. Naturally, I will pick food for our table."

It is apparent that this predicament affects all Americans. Obviously, those who do pay for their health care, either directly or through third-party payors, are subsidizing the care of those who cannot or do not cover their medical costs. The amount now spent on health care in our country is 11% of our gross national product, with this figure increasing. The increase can be attributed to a variety of causes. However, probably the primary factor is our advanced degree of technology in the field of medicine. Americans are not willing to pay the cost for the type of medicine that is available to them--the type of medicine that they expect and demand. Also, malpractice litigation and product liability are major factors contributing to the escalation of health-care costs.

As we address the problem of soaring health-care costs, we must also be concerned with the availability and accessibility of care for every American. Availability of care for the citizens of the panhandle of Nebraska and its surrounding region is being threatened. Solutions to the health-care problems must be sought out and made in a fair and equitable manner. The current Medicare reimbursement inequities based on a regional status is not fair and equitable and is in fact counterproductive to making health care accessible to the citizens of our region. Nebraska Panhandle citizens must pay the same Medicare Part B premium amount as citizens throughout the country. However, reimbursement amounts are not equal for medical services rendered, and, in fact, our "Locality" is consistently reimbursed at a decreased level when compared with other regions in the nation. A major problem arising from this situation is that physicians are leaving this region, and the recruitment of new physicians to the area is becoming increasingly more difficult. The Medicare reimbursement inequities is listed as a major factor in the decision of these physicians to refrain from practicing medicine in this area. As our physician population decreases in number, health care will become less and less accessible to those who need it. It will not be possible to obtain care in a timely manner, and the citizens of our region will be placed in a compromised situation.

Please consider these factors as you seek to resolve the problems that concern the citizens of our nation and especially those of the Panhandle of Nebraska and its surrounding region. Please consider a solution that is fair and equitable for all American citizens.

Sincerely,

Carmen Kleager, R.N.
Administrative Assistant, FALCO

LETTER FROM F.E. "WALLEY" WOLSKI

3 June 1990

To: The Honorable Senator Bob Kerrey
The Honorable Senator Tom Daschle

Ref: Senate Committee Hearing in Scottsbluff, Nebraska

Subj: Rural Health Care

I am a membership representative in this area for Communicating for Agriculture, a national non-profit association of farmers, ranchers, and rural business people. CA has always worked to pass legislation that betters the quality of life for rural America.

One area where CA has been particularly successful is with health care issues. CA has seeked fairness so that rural citizens are not penalized in access, quality, or price because of where they live.

Last September CA launched a national grassroots campaign, HEAR US, (Health Equity Across Rural United States) that has raised awareness for rural health care systems. The campaign addressed four equality issues and four cost issues.

On May 15, 1990 Communicating for Agriculture presented nearly 80,000 petition signatures of supporters at a Washington, D.C. ceremony. Of this total, 750 signatures were from this area.

I have enclosed reference material addressing individually each of the eight issues of the HEAR US campaign as well as the June issue of the CA Highlights publication.

Thank you Senators for your concerns with our problems here in rural America. If I can be of any further assistance please feel free to contact me personally or call the National Headquarters at 1-800-432-FARM.

"HEAR US!"

HEALTH EQUITY ACROSS RURAL UNITED STATES

FIVE REASONS WE NEED TO BE HEARD:

CONSIDER:

- In 1987, $500.3 billion was spent by public and private sources in the United States for health care, $2,048 for every man, woman and child in America. For 1988, the estimate was $558.7 billion, for 1989 the estimate is $620 billion and for 1990 it is expected to approach $730 billion, $2 billion per day, or nearly $3,000 for every man, woman and child![1]

- Individual federal income taxes collected in the United States in 1987 amounted to $1,906 for every man, woman and child. If the United States had enacted national health insurance in 1987 and paid for all health care costs, the average income tax to be collected would have had to be raised to more than $3,100. If current health care expenditures continue, the federal individual income tax in 1990 would have to be raised to more than $4,800 per man, woman and child, in addition to regular tax increases![2]

- In 1987, doctors and hospitals paid at least $8 billion in malpractice insurance premiums. Malpractice insurance costs for each baby delivered were $448 in Oregon, $572 in New York and an astounding $921 in Florida. Moreover, insurance premiums are only a part of the malpractice system. For protection, doctors performed an estimated $20 billion in unneeded tests and procedures, called "defensive medicine"![3]

- 37 million Americans live on the edge of disaster. They do not have any health insurance coverage!

- Rural hospitals are closing at an astonishing rate: 159 rural hospitals have closed their doors since 1984, 43 in the last year. Of the hospitals that lost money in 1987, 80 percent were rural.[4]

Communicating for Agriculture (CA) and the 100,000 individuals nationwide represented by CA have had enough and say "HEAR US!" Health Equity Across Rural U.S. ("HEAR US!") is a national grassroots campaign started by CA to raise awareness and generate support for major changes in the health care system in America.

CA is a national, non-profit, non-partisan rural membership organization based in Fergus Falls, Minnesota. It has long been recognized as a national leader on rural health care issues throughout the United States.

According to CA founder and chief executive officer Milt Smedsrud, "the time has arrived for citizens across both rural and urban America to stand up and say 'I've had it with the constant increase in the cost of health care in this country. I have had it with the problems of inequality in distribution, services and financing of health care. I want to be heard. 'HEAR US!' Elected officials, health care providers, insurance companies and all citizens must band together to solve this menace."

The CA national board of directors approved the launching of "HEAR US!" for Sept. 17 and directed the CA staff to generate a campaign which would accomplish the major goals. "What we want are proposals that will address and solve real problems, the kind of solutions CA has implemented for years. We are tired of hearing politicians and individuals in the health care system propose ideas which will never pass because of politics or cost. There are hundreds of proposals popping up in Washington and various state capitols, but most have little chance of passage. CA's thrust will be to propose a plan that politically has a chance of passage, is affordable and, most importantly, will begin to solve our health care problems".

CA is directing the "HEAR US!" campaign to two specific areas of the health care system, EQUALITY and COST.

EQUALITY ISSUES

On the equality side, CA proposes the following:

1. TAX DEDUCTIBILITY FOR THE SELF-EMPLOYED.

Self-employed individuals should be allowed a full 100 percent tax deduction for health insurance premiums. Currently, only 25 percent is deductible and this law will be wiped off the books at the end of 1989. CA has long supported this deduction and was one of the early supporters for the 25 percent deduction. It's just not fair that nearly all corporate executives receive their health insurance free of charge, yet self-employed Americans must pay for their own coverage and aren't even allowed to deduct the cost from their taxes.

2. RISK POOLS.

All states should adopt a health insurance risk pool. Simply put, a risk pool is a state-regulated health insurance program available to all citizens unable to purchase health coverage due to a pre-existing health condition. The plan offers these individuals the opportunity to purchase adequate coverage at a reasonable cost. CA has testified on this issue in more than 30 state legislatures and assisted most of the 18 states who have passed the legislation. Long recognized as the national leader on this issue, as a result of CA's efforts, more than 85 million Americans live in states that offer a risk pool.

3. EQUALITY FOR RURAL HOSPITALS.

Rural hospitals should receive an increase in the dollars they receive for Medicare reimbursement. As currently adopted, urban hospitals receive approximately 35 percent more dollars reimbursed for the same procedure and length of stay for a Medicare patient. CA has been pushing for this change through their current "Bandaid Campaign", by letting Congress know we are tired of bandaid solutions to this problem. Of the hospitals who lost money in 1987 in this country, 80 percent were rural. The problem of low reimbursement from Medicare hurts all rural residents, because hospitals shift costs from those covered by Medicare to the rest of us.

4. HEALTH CARE SAVINGS ACCOUNTS.

Individuals should be allowed to contribute tax-free dollars to such an account, similar to the popular IRA's. Such funds could only be withdrawn for medical emergencies or for the purchase of long-term care financing after reaching a certain age. Americans must begin to plan for future health costs, and providing this type of incentive would help them establish a self-insurance fund to defray catastrophic expenses, or fund the medical cost of retirement.

Adoption of these four proposals would assist in making the health care system more fair for those living in both rural and urban America.

However, CA believes the real culprit when addressing the health care system is costs. Providing access to more individuals or providing more dollars to the effort still doesn't address the ever-increasing rise in costs.

COST ISSUES

Therefore, CA proposes the following when addressing costs:

1. LIMIT MEDICAL MALPRACTICE AWARDS.

Such awards should be limited to actual damages and a pre-set limit on punitive damages. Estimates say nearly 25 percent of all health care costs are for tests not needed. Many of these are conducted because the health care provider must protect themselves from a malpractice case. We must not award millions and millions of dollars, on top of medical costs, to individuals who would never have earned this kind of money over their lifetime. Health care providers must be held accountable, but should not be infallible. The threat of malpractice has forced many providers to refrain from servicing many patients, thereby decreasing quality.

2. UTILIZATION REVIEW FOR ALL HEALTH PLANS.

All health plans should offer this service to their users. Very simply, utilization review allows an outside health care professional to determine whether specific tests or hospitalization are required. For plans now using this system, such reviews save up to 20 percent on medical costs. The quality of care is not decreased, only the costs for extended stays and unnecessary testing. CA was one of the earliest groups to adopt such a system for their major medical group plan several years ago and has been pleased by how well such a system works.

3. HEALTH CARE TREATED AS A PUBLIC UTILITY.

Health care rates and fees for doctors, hospitals and prescription drugs should be subject to rate reviews, the same as telephone and electric rates. Requests for increases should be reviewed and granted only with documentation for the need for such increases. In addition, all health plans should have mandated loss ratios. This means insurance carriers must pay out a certain portion of all collected premiums for direct health care costs. CA has long been a supporter of such a law and CA's home state of Minnesota has such a mandated loss-ratio law, one of the few in the nation.

4. PRICE FREEZE ON HEALTH CARE COSTS.

Prices and costs should be frozen to the rate of inflation for a period of at least two years while other solutions are studied. We must search for additional solutions to this growing problem and a freeze would protect thousands of individuals from dropping their current health coverage due to ever-rising premiums, thus protecting providers from increases in uncompensated care and individuals from possible bankruptcy.

According to Smedsrud, "These eight issues will be the focus of CA's "HEAR US!" campaign. No one proposal has all the answers, but we feel these eight definitely have the support of the people and many elected officials".

CA has outlined its campaign in a package to major elected officials in each state and in Washington, D.C., asking for their support and efforts in passing any required legislation. Several of these proposals have been introduced in the past, but many will have to be re-drafted for legislative consideration.

CA plans on doing whatever is needed to see that each of the proposals receives serious consideration, whether this be on the state or federal level.

HOW TO TAKE PART IN "HEAR US!"

How can each citizen become involved in this effort? CA is in the process of contacting other organizations throughout the U.S. for support and is conducting a major public relations blitz across the country, conducting media interviews and giving speeches to interested groups. A petition drive will be started to gather signatures from across the country to be sent to Washington, D.C. and state capitols.

Any individual or organization is invited to sign on with the campaign and participate in the petition drive. Materials for the petition drive will be provided by CA at no cost. Those who wish to become more involved can receive a new publication that provides tips on ways each person can control their own health care costs, as well as a bumper sticker, button, poster and a quarterly newsletter for a one-time $12 contribution.

As Smedsrud noted, "several years ago, CA said one of the biggest problems facing rural America in the 1990s would be health care. We have been very successful in focusing our efforts in alleviating this concern, but now our membership has asked us to expand this effort nationally, for they believe everyone has 'had enough'. We are listening and would like all of America to stand up and say 'HEAR US!'".

Directing the campaign for CA is Aaron Trippler, vice president of member services. He is recognized as the most knowledgeable individual in the nation on the issue of health insurance risk sharing pools. According to Smedsrud, "Aaron has been directly responsible for passage of nearly a dozen state risk pools, has assisted hundreds of national health-related associations and has addressed numerous legislative hearings and national conferences. CA is confident Aaron will provide this campaign with the leadership and enthusiasm required to enlist nationwide support and successful implementation of the "HEAR US!" proposals."

For further information on the "HEAR US!" campaign, contact Aaron Trippler toll-free at 1-800-445-1525 or (612) 854-9005.

SOURCES:

1. Estimates on health care expenditures from Health Care Financing Administration and Joseph A. Califano Jr., former Secretary of HHS. Population estimates from Touche Ross & Co. and Population Reference Bureau.
2. Estimates based on statistics from Health Care Financing Administration, Joseph A. Califano Jr., former Secretary of HHS, Touche Ross & Co., Population Reference Bureau and Communicating for Agriculture.
3. Statistics from Joseph A. Califano, Jr., former HHS Secretary.
4. Statistics from a report of the U.S. Senate Special Committee on Aging.

LETTER FROM BOB JANKY, MID-AMERICA HEALTH CARE

May 29, 1990

Senator J. Robert Kerrey
Western Nebraska Regional Office
2106 1st Ave
Scottsbluff, Ne 69361

Re: Rural Health Care Hearings for Senate Finance and Appropriations Committee.

Dear Senator Kerrey,

The cost of Health Care in the United States, including Nebraska has been skyrocketing in the past years. It will be a challenge for all segments of the Health Care Delivery System and the Government to bring this spiral of increased cost under control, and allow an equitable and affordable Health Care package to be enjoyed by the general population of this Country.

The majority of the population that needs Health Care is our elderly, over age 65, and the Federal Government has placed restraints on the Medicare Program to control costs. Still at this time the United States spends more of its GNP than any other country in the World for Health Care. I feel the reasons for this escalation of costs should be the primary target of our Congress to identify.

Typically premiums of the individual health insurance policy holders have increased significantly over the last ten years as charges for services increased. Third party payors, other than Medicare and Medicaid, seem to be paying large increases in their fee for service schedules where the government programs have made attempt an to control costs by initiating DRG's, etc. The end result has been that many families and/or employers have not been able to continue to pay these premiums for Health Insurance.

Are these increases in charges warranted? Does our Health Care System need these increases to maintain facilities that meet the needs of the communities they serve? If you look at the amount of venture capital that is available to expand facilities, or available cash to pour into other ventures not associated with health care, it would be a very good indicator of their true Financial Health.

The main competition in much of my service area is Hospitals, or monies generated from Hosiptal Groups that supply Home Care Equipment outside the Hospital setting. Why is money available for such ventures when the billing for services is rising so fast? There is an outcry from the public as to the cost of receiving Health Care Services. Why are we supporting a Health Care system that seemingly has such excess?

I am not an advocate of Socialized Medicine, but I feel that all aspects of the Health Care Delivery System should come under scrutiny as to the amount of monies it is able to generate. If large cash reserves can be generated the Federal Government should place restrictions on Not For Profit Organizations on their cash reserves, or make them pay taxes to regenerate tax dollars. I favor making sure that the Health Care System is being fair to the public, rather than shifting the responsibility of who is going to pay, such as Senator Kennedy's proposal to make Health Insurance manditory for Employers to pay.

The future for the rural areas in Nebraska seems to indicate that there will be a shift of Hospital services to the larger Cities in the state. It seems impractical for every town in the state to maintain a small Hosptial, although an emergency center, or clinic should remain for local medical services. Senator Baucus has a pilot program in Montana that outlines this type of program.

Sentator Daschle's proposal of the Nurse practictioner would be beneficial to insure that the outlying areas of the state that can not support or attract a full time Physicain, would have Health Care available to them.

In general the shift in Health Care is to discharge patients to home quicker as it is the most cost effective and provides patients with a better quality of life while they convalesce. In the past Home Medical Equipment (HME) has been the target of Presidential Administrations, and HCFA for reductions in payment for service. Since 1984, HME items received only a single Consumer Price Index (CPI) of 1.7% on January 1, 1987. Yet during this same time period, Gramm-Rudman reductions to HME occurred (1986, 1988, and 1990).

A new reimbursement system for HME, the six point plan, went into effect in 1989, which was to reduce oxygen reimbursement 5%. from the base year of reimbursement of 1986. The actual reduction was greater (as much as 10-15%) because the 1986 base year included low usage patients who no longer qualify for home oxygen therapy (Blood Gas Results).

HME represent just 2% of total Medicare outlays; yet the Administration has proposed cuts to HME expenditures of over $300 million for FY91, representing a 15% reduction in HME expendtures.

In the country three major HME national companies have been sold at distressed values in the last three years. Hundreds of smaller, privately owned companies have gone out of business through bankruptcy, or forced sales of assets. The adverse impact these closures will have on access to care for needy Medicare beneficiaries is yet to be seen. Information is from the National Association of Medical Equipment Suppliers (NAMES).

The Presidents FY91 budget notes proposed plans to conduct laboratory and HME competitive bidding demonstrations. Past Administrations have studied Competitive Bidding and studies showed that they were not feasible. At this time there is not a single company in Nebraska that could effectively bid and service the complete state. The large geographic area of the state would prohibit adequate service. Free enterprise in the market place seems to be the best tool for controlling price. The practice of awarding bids to select providers would eliminate many providers from the market place as the majority of services in this industry are to Medicare beneficiaries.

The six point plan has instructions for HME Medicare Part B to go to a regional pricing schedule in 1991 that implements state-by-state provider schedules into a Regional Pricing Schedule in 1993. (States included NE, KS, MO, IA, SD, ND, MN). Each of these states pricing schedules were developed from prior billing history in that state. The Administration is proposing that this regional pricing be initiated immediately in 1991. There is no information available on what the fiscal impact would be for the State of Nebraska Providers, and how it could effect their ability to provide services. The gradual step concept is preferred so providers can have time to adjust to the change of reimburement.

At this time there is approximatley 50 Insurance Carriers that contract with HCFA to process Part B claims. HME, and related supplies account for only 3% of all Part B claims that a carrier processes. The HME industry through NAMES has developed the policy that it would prefer Regional Carriers be set up to process HME claims. This would allow the Carriers to become more proficient in processing and would save administrative costs for HCFA to operate the program.

I appreciate you requesting my participation for submitting testimony to the Committee Hearings. To insure a quality Health Care System for Nebraska and the United States that is equitable for all parties, beneficiaries and providers alike, will be a great task but it is paramount that it be addressed and resolved.

Sincerely

Bob Janky

Bob Janky
Med-America Health Care

LETTER FROM CLARK GRIFFITH, RPH, MEDICAL CENTER PHARMACY

5/31/90

Sen. J. Robert Kerrey
2106 1st Ave.
Scottsbluff, NE 69361

Honorable Senator Kerrey:

I appreciate the opportunity to comment on my experience with rural health care in western Nebraska. As I have expressed in previous letters, I have had my greatest problem with reimbursement from our Medicare carrier. I operate a small business. I have supplemented my pharmacy business with Home Medical Equipment (HME). This was a satisfying adventure by assisting the disabled, handicapped and elderly with their medical needs. Being a pharmacist, I have dedicated my career to helping people in a honorable fashion. I have studied medicare laws and guidelines. I have contracted with a national billing company to take care of my medicare accounts. After taking these safeguards, I still have very poor "days outstanding" receivables. It was not until the honorable Virginia Smith stepped in, did I get some response on our very old accounts.

In my opinion, if a physician prescribes a piece of medical equipment for a patient, the physician should not be questioned and the patient should not be denied. I like to think our doctors are honorable and that I am honorable in what I bill medicare for the goods I sell and rent.

I know there are no immediate solutions for the problems of the nations health care system, but I don't believe the health care industry should take the blunt of medicare's cutbacks. The Administration proposes to take $250 million out of reimbursement of this small segment of the health care industry- that is, 6 percent of cuts would come from 1 percent of the Medicare program or 11.6 percent of the Administration's total $2.16 billion in Part B savings proposals. Since 1984, HME has received only one Consumer Price Index update of 1.7 percent (on Jan. 1, 1987). During the same seven years, we have had Gramm-Rudman reductions in 1986, 1987 to 1988 and 1989 to 1990. Further reductions are listed in enclosed article copied from Homecare magazine, May 1990. This article includes excerpts from Jerry Jone's written testimony. It describes our dilemma very well. I agree with his statement that the proper way for the Office of the Inspector General to correct program abuses is to require HCFA to correctly and precisely define medical need, not to attack an entire industry.

If receivables, profits and return on investments continue to decline, small, honest businesses like mine will not be able to survive. If we don't survive, the quality of health care will decline and deceiving minds will flourish.

Sincerely,
Clark Griffith
Clark Griffith RPh, owner

[From Homecare magazine]

JONES TAKES A STAND ON BUDGET BEFORE SENATE FINANCE COMMITTEE

WASHINGTON, D.C. — Taking a stand as a consumer, a businessman and a home care industry spokesman, Jerry Jones in late March faced the Senate Finance Committee on the $215 million DME cut in the Administration's '91 budget proposal.

While he presented written testimony to the committee, he was given only five minutes to verbally address key points, Jones told *Homecare®*. He is president of Homedco, Fountain Valley, Calif., past chairman of the Health Industry Distributors Association and a board member of the National Association of Medical Equipment Suppliers.

What did Jones think of competitive bidding was asked by Sen. John Rockefeller, D-W.V. "While the competitive bidding portion was not in the written text," Jones said, "I was prepared for the question.

"The biggest problem is: How to implement a design to provide access to and quality of health care to beneficiaries. How do you break up the entire U.S. into service units? And how do you match providers who can provide those products?

"Then you have a complete matrix of service components. The design is a real problem. Being able to develop consistent service for all products, particularly for rural areas, is difficult.

"The ability of dealers to obtain a bid and get the money to buy equipment to service patients is questionable," Jones said. "Some of the largest companies with the better financial capabilities are at an advantage.

"If, however, the Senate Finance Committee considers competitive bidding a strategy, I asked that the industry have an opportunity to work in partnership with the government to design a program. Also, a demonstration program must run for three years, minimum, to determine the long-term impact to beneficiaries' access to quality health care. Service must be available in rural markets. The industry must have the ability to fund and provide service in competitive bidding markets. And, we hope a demonstration project is subject to evaluation." — *A.S.*

Excerpts From Jones' Written Testimony

☐ The administration of third-party claims by Medicare carriers, HME suppliers and beneficiaries is inefficient, creating both unnecessary administrative costs and inappropriate outlays.

Moreover, there are emerging risks to Medicare beneficiaries of not receiving HME services due to barriers or inconsistent interpretations created by problems in claim processing administration. Access to Common Working File at time of service, timely processing of unclean claims, standardized processing systems or specialty/regional carriers, are all efficiency correcting areas.

☐ The Administration proposes to take $250 million out of reimbursement for this small segment of the health care industry — that is, 6 percent of cuts would come from 1 percent of the Medicare program or 11.6 percent of the Administration's total $2.16 billion in Part B savings proposals. (The Congressional Budget Office re-estimated the President's budget proposals for FY 1991, reporting a 28 percent higher cost-saving value for proposed cuts in Medicare DME spending ($320 million) than the Office of Management and Budget's $250 million estimate.)

☐ Since 1984, HME has received only one Consumer Price Index update of 1.7 percent (on Jan. 1, 1987). During the same seven years, we have had Gramm-Rudman reductions in 1986, 1987 to 1988 and 1989 to 1990. On top of these reductions, HME reimbursement has been further reduced by:

- 1985: A delay in reasonable charge update, July through September;
- 1986: A freeze on all reasonable charge increases, October 1985 through December 1986;
- 1987: The reasonable charge update was limited by inflation-index charges of 1.7 percent, January through May 1987;
- 1988: A reduction of lowest charge level (25th percentile) from the 75th percentile, May 1987 through December 1988; and
- 1989: 5 to 30 percent reduction in oxygen reimbursement, June 1989 through the present.
- 1990: A freeze on all reasonable charge increases through 1990.

The overall impact of these various reductions means that:

- Medicare pays for sale items at 1983 prices with up to a 1.7 percent increase, less current Gramm-Rudman reductions, and
- Medicare pays for equipment rental items at 1986 prices, less current Gramm-Rudman reductions, with no CPI increases.

☐ The Six-Point Plan will phase-in regional fee schedules for oxygen and most rental items beginning January 1991. The regional fee schedule amounts will be further reduced through a process of limits based on allowed national variation, phased in during 1991 and 1992. Thus, the White House proposal would abandon the phased implementation of a complex new law for an important Medicare benefit in mid-stream. We strongly object to such a change and continue to support the original plan Congress enacted in 1987.

☐ Regional, not national, fee schedules is the only system which makes sense for this industry. The HME business is inherently a local business. It is also primarily a service business, 24 hours a day, seven days a week, where labor costs are the single greatest expense.

☐ The Six-Point Plan authorizes HCFA to establish regional or specialized carriers to process HME claims. Regional or specialized carriers would result in significant management and processing efficiencies.

☐ Although the Medicare law refers to this important benefit as durable medical equipment, in fact, according to a 1987 study by Ernst & Whinney, "Equipment acquisition is a relatively insignificant element of overall costs." The costs of providing HME are, therefore, not simply based upon the cost of the product, but upon the cost of providing the service in local communities.

☐ According to a definitive industry survey by Prof. Ronald Stephenson, Ph.D., of Indiana University, average profits and return on investments have declined by 50 percent in the last six years.

☐ The proper way for the Office of the Inspector General to correct program abuses is to require HCFA to correctly and precisely define medical need, not to attack an entire industry.

STATEMENT OF RALPH D. HEASLEY, DIRECTOR OF BUDGET AND REIMBURSEMENT, REGIONAL WEST MEDICAL CENTER

The theme of "The Future of Rural Health" and further how Nebraska is addressing rural health care delivery and financial issues may be more appropriately phrased, "how Nebraska is surviving with rural health care delivery and financial issues. In my opinion, the delivery of healthcare to this point has met the public need.

The professions and mission to which we dedicate ourselves have proven to be strong enough to withstand many changes and adversities. The real issue is whether in the 1990's, rural citizen healthcare needs can be met, given the limited resources and bureaucratic hoops healthcare providers and practitioners must contend with when participating in the Medicare and Medicaid programs.

It is interesting to review how this present Medicare system (PPS) evolved. This change alone has probably impacted hospital finance more than any single issue. On April 20, 1983 President Reagan signed into law the Social Security Amendments of 1983. One of principle provisions was to curb the rapid growth of Medicare Hospital costs.

Other advantages cited were:

- It is easy to understand and simple to administer.
- It can be implemented quickly.
- It ensures both hospitals and the federal government a predictable payment for services.
- It establishes the federal government as the prudent buyer of services.
- It reduces the administrative burden (simplifies the payment and reporting process) on hospitals and provides rewards to the hospital administrators to operate efficiently.
- It will result in improved quality of care as hospitals begin to specialize in what they do best.
- Beneficiary liability will be limited to the coinsurance and deductible payments mandated by Congress.

In a letter from the GAO to Sen. Bob Packwood (HRD - 82 - 73, May 10, 1982) discussed the prospective payment concept. One important point covered in that letter is:

"Prospective reimbursement systems can be designed to achieve almost any level of program savings desired, although there comes a point when reduced reimbursement could adversely affect access to care and / or quality of care. Also, if the system does not apply to all payers, there may be incentive for a facility to shift cost to noncovered payers."

In another report to Congress from the Department of Health and Human Services (December 1982) the ultimate objective of PPS was identified as "... to set a reasonable price for a known product. This provides incentives for hospitals to produce that product more efficiently. When PPS is in place, health care providers will be confronted with strong, lasting incentives to restrain costs for the first time in Medicare history."

The prospective payment system I believe was a necessity for the health care industry at the time of its' implementation. It caused us as managers, for perhaps the first time, to view our work as a business. As a result of this we began focusing more on ways to operate our business more efficiently and yet maintain and in some instances improve the quality of care being rendered.

At Regional West Medical Center, in the first year under PPS, our Medicare average length of stay was reduced from 8.12 to 6.92 days (17%). As of the end of fiscal year 1989 our average Medicare length of stay was 7.52 days. However, the types of patients we our treating have consistently become more severe as evidenced by our Medicare case mix index. This intensity factor has increased from approximately 1.0300 at 10-31-84 to 1.3111 at the end of federal fiscal year 1989.

As case mix intensity has increased by nearly 30% since 1984, our Medicare cost per inpatient case (adjusted for case mix intensity) has increased from $2247 to $2679 (19%). In contrast, our inpatient payment increases from Medicare have increased by 15% since 1984. It is accurate for us state that on the average Regional West Medical Center now incurs a loss for every Medicare patient treated. We are technically being paid less per case than under pre-PPS cost reimbursement principles, even though we have effectively responded to the containment of rapid cost escalation.

The 1982 HHS report to Congress was correct regarding the incentives for hospitals to produce a product more efficiently. Equally accurate was the GAO letter which pointed out that although almost any level of program savings desired can be achieved, there comes a point when reduced reimbursement could adversely affect access to care and / or quality of care, as well as, create incentives to shift costs to other payers.

These things have happened and continue. There are only certain sources of cost growth that hospitals can control. That is, PPS has created incentives for economical responses to outside influences, but PPS has not eliminated their effects. For example, hospitals can respond to price increases in supplies, drugs, etc., but we can not prevent the increase. Also, how a hospital can respond to resource utilization incentives depends largely on the ability to transmit these incentives to the attending physician staff, for which there is no direct control.

More specifically, rural hospitals were placed in the back seat from the start of PPS. The payment rate differential between the urban and rural pre-wage and case mix adjusted standardized amounts was greater than 30% in 1984 for our region. Currently, this differential is 11% and we commend the efforts and support given by our congressional leaders in reducing this disparity.

These differences over the past 6 years have literally shifted millions of health care dollars from rural providers to urban providers. Regional West Medical Center is considered a sole community provider and a regional referral center and as such receives some adjustments that most rural hospitals do not receive. Even so, because of the wage index factor, had our facility been located 30 miles to the west in Wyoming our increased payments from Medicare would have exceeded $2.5 million over the past six years.

PPS allows payment for extraordinary/catastrophic cases, but only at a fraction of the cost of rendering care. One example at Regional West Medical Center is a patient with an account balance of $145,000, with a length of stay of 54 days, and our Medicare payment is projected to be $11,816. The patient or supplement insurance will be responsible for the annual deductible of $592. The balance of the account must be written-off as uncompensated care, because we participate in the Medicare program.

This is not an isolated case. As the regions primary referral center we treat many severely ill patients for which payment from Medicare and Medicaid falls far short of the cost of treatment. Again, there are some incentives for being a RRC and SCH, but such incentives do not out-weigh the financial losses just noted. Cases like this can be devastating to much smaller, but necessary community hospitals.

Indeed, there appear to be merits for not participating in the Medicare program. If we could bill patients or their insurances and expect payment for what we charge, it is very realistic that Regional West Medical Center could reduce charges categorically and significantly for all patients. Since over 50% of our cases represent Medicare and Medicaid beneficiaries and recipients and since our cost are not being met by these payers, our charges must remain higher to offset these losses.

A recent study by researchers at the Harvard School of Public Health presents evidence that car for the poor probably entails longer hospital stays and greater use of resources and the range of difference is generally on the order of 5 to 25 percent more. So we have a lower payment base when compared to urban facilities, but yet we treat as high if not a higher percentage of poor cases which are more costly. It is really a paradox that we are dealing with here at Regional West Medical Center and in rural health care in general.

To review a few of the advantages of PPS noted earlier:

1. Yes, in theory this system should be easy to understand and easy to administer. But, we continue to complicate it with adjustments for this type of facility and that type of facility. In other words everyone looking out for their best interests. The initial administration was relatively easy, but no longer.

2. Yes, It ensures both hospitals and the federal government a predictable payment for services. But, in reality we had that on a larger scale before PPS. Hospitals new that the Medicare specified cost of caring for patients would be covered. Currently, our cost is not being covered even though efficiencies have reduced the growth of expenditures here at Regional West Medical Center.

3. No, It has not reduced the administrative burden (simplifies the payment and reporting process) on hospitals and no it has not provided rewards to Regional West Medical Center for operating more efficiently. It has only served to squeeze costs down. Administratively, we and our medical staff are required to maintain more documentation, file as many or more reports and must contend with more bureaucracy, i.e. (PRO) than before.

Finally, hospitals and more and more physicians are phased with the prospect of the further expansion of PPS to include skilled nursing facilities, outpatient services, home health services, fee schedules based on resource-based relative value scales. How should interpret these proposals. As tax payers we can appreciate reduced governmental spending, but not at the expense of caring for our elderly and the poor.

I believe we are better consumers of services, but what has happened to the reliance upon a physicians highly educated and professional judgement? Must we spend our health care dollars constantly checking and second guessing admission necessity, procedural methods? I think not and with all of the recent international changes, I would hope that more tax payer dollars can be prudently and equitably utilized for our nations health care.

RECOMMENDATIONS

1. A reduction in the monitoring functions now in place. (Auditing, PRO, Cost Reporting). "Right to work functions"

2. A combination of hospital and physician payments that rely on mutual cooperation.

3. Provisions to appeal inequities in payment. i.e. wage indices.

4. Incentives for facility networking (sharing of services).

LETTER FROM ALFRED K. MARRON

Senator Bob Kerry
308 Hart Office Bldg.
Washington, D. C.20510

Dear Senator Kerry:

Americans abhor discrimination in any form; However one of the worst offenders of discrimination is the Health care Administration.

Medicare reimbursement disparity is one of the reasons that we in western Nebraska are having difficulties keeping any family physicians. Our local (and only) physician left this area recently to be in an area where he could be adequately reimbursed for his services to his patients who are in the most part elderly.

Your assistance in removing this terrible discrimination against rural doctors and hospitals will help alleviate shortages in the medical field.

Thank you for your cooperation.

Sincerely,

Alfred K. Marron

Alfred K. Marron

May 24. 1990

STATEMENT OF ROBERT L. DRIEWER, CHIEF EXECUTIVE OFFICER, MEMORIAL HOSPITAL & HOME

Thank you for the opportunity to present testimony regarding rural health.

Today, there are two major difficulties affecting the delivery of health care services in rural Nebraska. I belives they have national significance.

1. There is a growing number of individuals and families which fall through the gaps in the private and public system for healthcare financing. The systems that have evolved over the years have an enormous . void which affects a growing number of people in the rural areas.
2. There is a growing inequity in the access to healtcare services which is being caused by geographic mal-distribution of healthcare facilities and professionals. The inequities between urban and rural reimbursement for both physicians and hospitals for the provision of services is the single factor causing this problem.

I would ask you and your colleagues to use the following criteria as basis for future health care reform.

1. All individuals should have access to at least basic healthcare services.
2. The delivery and financing arrangements from both the public and private sectors should ensure the effective management of medical conditions.
3. All public financing arrangements must on their own bear the cost of services provided to their beneficiaries according to the terms of the agreement.
4. Purchasers of health benefits should be allowed to select benefits and delivery arrangements which emphasis "value" by emabling them to obtain the kind of care which they are willing and able to purchase.
5. The delivery arrangements between subscriber and provider should be at the local level and should recognize community variations in medcial practices consistent with quality care.

Reform is needed, and I believe it behooves all of us to evaluate the delivery and financing arrangements as they exist today. We must all develop a cooperative attitude as we begin to define a basic level of care. The public system must meet the needs of those who cannot meet their basic needs.

Thank you again for this opportunity.

Respectfully Submitted

Robert L. Driewer
Chief Executive Officer
Memorial Hospital and Home
Sidney, Nebraska

STATEMENT OF PETER BEESON, NEBRASKA DEPARTMENT OF PUBLIC INSTITUTIONS

My name is Peter Beeson, and I am here testifying for the Nebraska Department of Public Institutions. The Department appreciates this opportunity to speak on behalf of the citizens of the state for whom we provide mental health, substance abuse, mental retardation, and other specialized services. The Department also commends Senators Kerrey and Daschle for their attention to the important area of rural health care. The Department's position is that:

MENTAL HEALTH IS AN INTEGRAL AND IMPORTANT PART OF RURAL HEALTH CARE

In this testimony I intend to make five points: (1) there is a strong interrelationship between physical and mental health; (2) the need for mental health services in rural areas is increasing; (3) the resources available to meet mental health needs in rural areas are decreasing; (4) Nebraska has taken positive steps to address rural mental health issues; and (5) there are things Congress can do to effectively respond to mental health needs of rural Americans.

I. Interrelationship Between Health and Mental Health

The distinction between mental health and physical health is in many ways artificial. Mental and physical well-being within a single individual are intimately intertwined, interactive, and interdependent. The state of one's physical health has direct impact on one's mental health and conversely, state of one's mental health has direct consequences for one's physical health. Patients seeking help from the general health care system are likely to have concomitant mental health problems, and patients seeking help from the specialty mental health care sector are also very likely to have physical health care problems. In the course of a year the specialty mental health sector treats only 21% of all persons estimated to have mental disorders. Fifty-four percent of all persons with a diagnosable mental disorder in the United States seek treatment exclusively in ambulatory general health care settings. Although the frequency of psychiatric disturbance in primary care settings is not known with certainty, evidence suggests that 30-60% of patients in the general hospital units and 50-80% of general practice outpatient patients suffer from emotional stress of sufficient severity to pose problems in medical management. In addition, careful physician and laboratory examination of psychiatric outpatient and inpatient populations have disclosed concurrent psychiatric and medical disorder in 30-50% of patients.

Rural mental health care faces many of the same problems confronting the whole of rural health care: shortage of mental health care professionals, poor access to care, lack of psychiatric emergency services, increasingly poor resource base, etc. It is, therefore, critical that when we consider the issues of rural health care we treat mental health as an integral and significant part of rural health care.

II. Increasing Need for Mental Health Services in Rural Areas

A. Historical Perspective

While the farm crisis has focused the national spotlight on the mental health needs of rural Americans, it is important to recognize that there were significant mental health needs in rural areas prior to the farm crisis, and there continue to be significant, if not greater, mental health needs among rural Americans, even without the national spotlight of the farm crisis. Rural areas have always had higher rates of manic-depressive illness, suicide, and alcohol abuse and less access to specialized mental health services. This continues to be the case today. With respect to mental health, rural America labors under a triple burden: (1) high levels of mental disorder, disability, and impairment; (2) inadequate mental health services and professionals; and (3) a public perception of rural areas as a stress-free mentally healthy living environments.

B. Farm Crisis/Rural Crisis

The 1980's were witness to a dramatic and social restructuring of rural America. At first, these changes were referred to as the "farm crisis" and then later the "rural crisis," but today there is general recognition that the term "crisis" is inappropriate. The changes taking place in rural America are neither short-term, temporary, or likely to return to the way things were. Rather, the changes in rural America, that so accelerated in the 1980's, represent a permanent and continuing reshaping of the reality of rural life. These changes have, and will continue to have, a great human cost associated with them at a time when resources available to persons living in rural America have decreased at an accelerating rate.

One of the key indicators of this "human cost" is an increase in the rates of mental disorder and mental health problems in rural areas. A Nebraska study (Beeson and Johnson) looked at the changes in the mental health status between 1981 and 1986. 1981 was the height of farm land values in Nebraska, and there was a precipitous decline after that. Between 1981 and 1986, the estimated rate of depression among farmers rose from 10.7% to 21.4%, and the overall estimated rate of mental health problems jumped from 6.2% to 14.6%. During the same period, residents of metropolitan areas evidenced a decline in depression of 2% and only a 1.1% increase in overall rate of mental health problems. A similar study (Hoyt) in Iowa found that just over two out of every ten residents in both rural farm and rural nonfarm populations could be classified as either possibly or probably depressed. That study also found a strong relationship between the economic stress of the farm economy and depression as well as the effects of the drought and depression.

The good news is that the farm economy has improved somewhat, and this improvement has resulted in a concomitant improvement in the mental health status of farmers. This improvement, however, has not returned farmers to the same level of emotional well-being that they experienced prior to the farm crisis. Unfortunately, these improvements have not reached the nonfarm and small town residents where recent research indicates increasing mental health problems. It is likely that the social and economic restructuring of rural America will continue to have a negative impact on the mental health status of rural residents.

C. Meeting the Mental Health Needs of Rural Americans is Not the Sole Responsibility of the Public Mental Health System

Mental health needs are quite pervasive and show up in every aspect of our society and in every segment of our citizenry. Too often, there is a tendency to either dismiss mental health needs as a personal issue that each individual must deal with or to relegate all mental health needs into a responsibility of the public mental health system. Neither of these approaches will result in an effective and positive response to the pervasiveness of the problem. Meeting the mental health needs of rural Americans is in some sense the responsibility of many sectors of our society. The public mental health sector does not have the resources to respond to all mental health needs.

The public policy position should be that if an agency, program, or organization requires mental health services to effectively carry out their mission then that agency, organization, or program should be responsible for ensuring that those services are provided. For example, in rural hospitals, some capacity to address the mental health needs of the service areas should be developed, ranging from crisis response/emergency to outpatient and coordinated with the public mental health system. It is difficult, if not impossible, for a health care system to offer emergency services if they don't have the capacity to deal with mental health and substance abuse issues.

III. Decreasing Resources

Not only are mental health needs increasing in rural areas, but the resources to effectively respond to those needs are decreasing. Nebraska, like many states, relies on local tax revenue to directly support mental health services and to match state funds. With a declining economic base in rural areas, the ability of local communities to generate resources in support of mental health services is declining. In addition, individuals in rural areas are less able today to provide for their own care. Increasingly, rural areas are being dominated by dependent populations such as the elderly and children, and many rural residents, faced with tough economic times, have given up health insurance. Private and charitable organizations are also finding themselves in tough times in rural areas. Many churches are folding, and what little private charitable efforts that were available are having a more difficult time generating revenues needed to support human services.

IV. Positive Responses to Rural Mental Health Needs in Nebraska

A. Rural Mental Health Demonstration Grant

Partly based on the research that Nebraska has already accomplished and partly based on work being done at the local level in northeast Nebraska, the State was able to receive one of four Rural Mental Health Demonstration Grants for $300,000. One of the key aspects of this grant was to try some new ways of providing mental health services to rural citizens. Two different approaches were utilized: (1) a mental health professional was placed full-time in the Northeast Nebraska Ag Action Center (a one-stop shopping center for distressed farmers); and (2) a mental health professional was located on a circuit riding basis in three rural primary care physicians' offices. In each location free mental health services (up to six visits)were provided, and the mental health services were overseen and backed up by the local community mental health center. These services were provided for an 18-month period and over 300 individuals were served. In both cases, not only were the services positively received by the clientele, but the services provided by the hosts of the sites were also enhanced. Based on these efforts, the Department, in conjunction with the University of Nebraska Extension Division, was able to use some Rural Crisis Recovery Act Funds to continue to support the services at the Ag Action Center, and we are currently working with local mental health providers to try to reestablish the services in the rural physician's office in Hartington (P.L. 94-142).

B. Critical Incident Stress Debriefing

Another important Nebraska initiative deals with mental health prevention activities in rural areas. One of the significant problems in rural areas is how to keep and maintain the various volunteer professionals that provide health, fire, and police services to rural citizens. In the case of emergency medical services and fire services, most rural areas are entirely staffed by volunteers. Recent years have seen an increasing turnover in these volunteers as they become burned out from the stresses of their work. In 1987, the four state agencies (Nebraska Department of Health, Nebraska Department of Public Institutions, the State Patrol, and the State Fire Marshal's Office) collaborated on the development of a program that provides educational and preventive interventions designed to help emergency responders cope with the stresses and emotional trauma often encountered in their jobs. This program (the Nebraska Critical Incident Stress Debriefing Team) is now in full operation across the state. The team is manned by mental health and peer volunteers who provide prevention, education, and actual post-incident debriefings designed to reduce the long-term psychological distress of emotional trauma.

V. What Can Congress Do?

A. Ensure that any rural health care initiative specifically addresses mental health needs of rural citizens and provides adequate resources for responding to those needs.

In developing a federal response to the crisis in rural health care, it is imperative that mental health be given specific and special attention and that resources be targeted to meet the mental health needs of rural citizens. Currently, the public mental health system does not have the resources to adequately respond to all the needs of rural citizens with mental health problems, and if mental health needs are not specifically addressed in rural health initiatives, they will be quickly and easily overlooked.

B. **Promote a better integration of health and mental health services in rural areas.**

In designing a Congressional response to the crisis in rural health care, specific attention should be given to ways in which such legislation could further promote a better integration of health and mental health services in rural areas. This might include specific grant programs designed to increase integration between those two service systems.

C. **Ensure that federal programs targeted to improving the economy and quality of life in rural areas adequately address the mental health needs and include resources specifically for that purpose.**

The programs of rural revitalization and rural economic development often ignore the fact that reasonable mental and emotional health are prerequisite for the effective utilization of these programs. This is especially true of programs that are designed to be self-help efforts, such as job retraining, career counseling, legal and financial assistance, etc. The key component to effective utilization of any of these programs is that individuals be able to make good sound life decisions and that they be able to effectively learn. Both decision making and learning are impaired when an individual is under emotional stress. Experience with the Ag Action Center in Nebraska has taught us that professional mental health services are an important component and necessary adjunct for the effective utilization of these kinds of services by distressed farmers. The public mental health system cannot and should not be relied on to provide these kinds of services, especially without additional resources. The system right now is struggling under the burden of meeting the needs of severe and persistently mentally ill, and doesn't have the resources to respond to these more moderate mental health problems.

D. **Ensure that federal programs focus their efforts and requirements on the outcomes desired rather than on the processes designed to achieve those outcomes.**

One of the biggest barriers for rural areas in making effective use of federal resources is that grant programs and other regulatory requirements are often inflexible in the ways in which they mandate that services be delivered or programs be carried out. In rural areas, there is often great potential and great ingenuity and the outcomes desired can often be achieved in ways which cannot be anticipated by federal bureaucrats. But when specific types of individuals are required to deliver services, when particular types of processes or requirements are set forth, rural areas often are unable to comply, and therefore, miss out on badly needed resources.

E. **Ensure that funding, regulatory and planning requirements of the federal programs do not discriminate or place undue burden on rural service providers.**

The impact on rural areas of federal programs needs to be adequately assessed before they are implemented. Clearly, we must learn from the example of the differential payments in the Medicaid program that more needs to be done to "check out" the consequences of various federal initiatives on rural areas and rural citizens.

STATEMENT OF ART MACHADO, NEBRASKA DEPARTMENT OF PUBLIC INSTITUTIONS

Senator Kerry, Senator Daschle, Good Afternoon.

I am Art Machado of the Nebraska Department of Public Institutions. On behalf of the Department, I would like to express our gratitude for this opportunity to testify and our recognition of and our appreciation for the Committees' interest in a matter of such great importance to all of Nebraska's citizens.

The Department exercises rural health related responsibilities as the State's mental health and substance abuse services authority. We also provide long term care services to rural citizens through the State's four Veterans Homes -- and these are important services for many rural families in communities around the state -- but this afternoon I will be confining my testimony to the Department's more universal health service areas: mental health and substance abuse services. The Department's position is that:

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES ARE AN INTEGRAL PART OF RURAL HEALTH CARE

In this testimony I intend to address: (1) the strong interrelationship between physical health and mental health; (2) the need for mental health and substance abuse services in rural areas; (3) human resources shortages in mental health and substance abuse and the impact that has in rural Nebraska; (4) some responses we have made to rural mental health and substance abuse service challenges; and (5) what Congress can do.

I. Interrelationship Between Physical and Mental Health

Rural mental health and substance abuse services are vital parts of the broader rural health care issue itself; and as such they are key to the prosperity and even survival of rural communities across the nation. The state of one's physical health has a direct impact on one's mental health and, conversely, the state of one's mental health has direct consequences for one's physical health. Patients seeking help from the general health care sector are also very likely to have mental health care problems. Substance abuse and its consequences correlate closely with both physical and mental disorders as well. So on the clinical level, physical and mental health just do not separate easily into distinct domains. It makes good sense, then, not only to examine these needs in a holistic sense, but also to consider service responses in the same light. This is particularly true in the special context of rural health care.

II. Mental Health and Substance Abuse Services Needs in Rural Areas

Rural mental health care faces many of the same problems confronting rural health care in general: there is a shortage of mental health care professionals, poor access to care, lack of psychiatric emergency services, an increasingly poor resource base. But there are some aspects of the current rural situation that work special hardships on mental health and substance abuse patients: widely dispersed providers and the lack of public transportation, the need for mainstream social and economic activity in an era of diminishing rural vocational opportunities, the need for family and community support while the ability of rural families and communities to provide such support is under pressure in many areas of the state. It is the special needs of rural citizens and the narrowed resource base in rural communities which argue strongly for an integrated approach, both on the system level and on the local level, to meet those needs.

I would like to turn now to some of the more specific and pressing mental health and substance abuse factors in the general rural health care needs equation.

A. Substance Abuse Services

In the area of substance abuse services, we need more adult and youth outpatient services, particularly the intensive outpatient and partial care approaches designed to handle those cases which would otherwise be treated in inpatient clinics away from the patient's job, family and community. Fortunately, there is new federal interest and new federal money in this area, and the State is working hard to direct these resources toward organizing the kind of system we need and to creating the requisite level of problem awareness. Rural citizens and rural communities are not accustomed to confronting mental illness or substance abuse as health problems requiring the same kind of professional service response required for recognized physical illnesses.

B. Psychiatric Emergency Services

Psychiatric emergency services are practically nonexistent in most areas of rural Nebraska. The private sector has not found it economically attractive or even feasible to develop such services -- a widely dispersed clientele, lack of insurance or other reimbursement options, the shortage of mental health - professionals, and competing health care priorities are all parts of the explanation. The State has only three state-operated psychiatric hospitals, and they are not convenient to most rural Nebraskans. Moreover, they are designed for long term inpatient care and so are frequently not appropriate for the acute care episodes that characterize most psychiatric emergencies. Since this is a key gatekeeping function in the mental health service system -- providing stabilization, assessment, short-term treatment, and an opportunity to arrange a long term response -- we view the development of psychiatric emergency services as an urgent need. Again, we think there should be an integrated approach. Emergency response teams should not have to guess whether the patient's problem is psychiatric or physical or substance abuse related or some combination of these.

C. Services for the Severely and Persistently Mentally Ill

Another important rural mental health service which is not very well developed in Nebraska's more rural areas is service for people with severe and persistent mental illness. The kinds of services needed for the rural element of this population are services based in and designed for small rural communities; services designed to rehabilitate and to integrate or reintegrate the patient as much as possible into rural community living. This can be a very different proposition from the scattered site housing and sheltered workshop approaches of larger cities.

III. Human Resource Problems

A. Shortage of Mental Health Professionals

An area of special need is the need for professional mental health service providers. Of Nebraska's 133 psychiatrists, 114 are in the Omaha and Lincoln health planning areas. There are only 19 in the rest of the state. The entire Panhandle area has only 3 and West Central Nebraska, an 18-county area with population centers like North Platte, Ogallala, Lexington, and McCook has only one. The case of clinical psychologists is similar. Our 1985 survey found that only eighteen of Nebraska's ninety-three counties had clinical psychologists. Naturally, recruiting more rural mental health professionals is a major concern, and we need help from the federal government in this area -- but more about that later.

B. The Role of the Primary Care Provider

Until there are adequate numbers of rural mental health professionals, many rural citizens will be getting mental health services from the primary care health system. In fact, national surveys show that more than 50% of people with a diagnosable mental disorder seek treatment exclusively in the general health care sector. The percentage must be considerably higher in rural Nebraska with its scarcity of mental health professionals. This is another reason we stress the importance of health and mental health system integration in rural areas. Since the rural primary care or family practice physician must in many cases make not only the first but sometimes the sole mental health response, it is crucial that rural physicians be comfortable and competent to deal with mental health problems and that they be linked effectively with the specialized mental health system.

IV. Positive Responses to Rural Needs

Linkage with the primary care system was one of the major thrusts of Nebraska's Rural Mental health Demonstration Project; which placed rural mental health professionals in physicians offices in rural communities to see how well that would work, to consider its policy implications and to consider ways to make work better.

The project also aimed at making rural citizens themselves more aware of and more accepting of mental health care as part of general health care. We prepared a stress awareness booklet designed to do exactly this and we distributed some 6500 copies of it to mental health centers, extension agents, physicians, ministers, school counselors and child guidance centers around the state. We also developed elementary school materials (a mental health activity book and accompanying teachers' guide) for schools around Nebraska. And we are currently finishing up production with Nebraska Educational TV on a videotape designed to train, orient and maybe even recruit mental health professionals for service in rural Nebraska.

In the area of rehabilitation services to the severely and persistently mentally ill, one of our most promising initiatives is the expansion of "Clubhouse" programs to rural Nebraska. We have them now in Scottsbluff, North Platte, Hastings, Columbus, Norfolk, Lincoln, Omaha and Grand Island. These are rehabilitation oriented programs, designed to perform the community integration or mainstream role, i.e., rehabilitating, integrating and supporting severely and persistently mentally ill persons in or close to their own communities. It is the community connection, this community tailoring that makes the "clubhouse" an ideal service model for Nebraska's surprisingly heterogeneous rural communities.

Psychiatric emergency services as a state wide program is just getting off the ground. Of course, we have had services in Lincoln and Omaha.

We now have services in Scottsbluff, and a few beds have just opened in Chadron and Alliance, but most of rural Nebraska remains underserved in this area. This area is receiving major emphasis in current state-level mental health planning.

On substance abuse services, in addition to channeling the new Drug Bill money toward our intensive outpatient and partial care priorities, we are also tying emergency substance abuse services to emergency psychiatric services since many clients, especially those needing emergency services, are people with dual substance abuse/mental illness diagnoses. Again the emphasis is on an integral and integrating approach.

In fact, the Department feels that whatever specialized service challenges are out there, and whatever the means we choose to respond to them, both needs and response must be seen and treated as part and parcel of the broader rural health care challenge. We would be wasting very scarce resources -- and a unique opportunity -- if we were to pursue totally distinct and disassociated health, mental health and substance abuse service strategies.

V. What Can Congress Do

In closing, I would like to briefly outline some of the areas in which we must look to the federal government for support:

- In the area of general health policy development, we ask that all federal rural health care initiatives specifically and automatically address the mental health and substance abuse needs of rural citizens and provide adequate resources for responding to those needs. For example:
  - policy should promote and support better integration of health, mental health, and substance abuse service systems.
  - special funding should be provided to train rural primary care physicians in mental health and substance abuse service responses.
  - federal programs such as the National Health Service Corps and Clinical Training Grants should emphasize rural mental health disciplines such as psychiatry, clinical psychology, psychiatric nursing, and clinical social work.
  - federal programs and regulation should focus on the competencies needed by people to deliver services and not on particular

disciplines or credentials; in the substance abuse field, for example, competency is based largely on experience and federal requirements for educational credentials would be particularly disruptive.

- priorities should be established which recognize and focus on extremely low density population areas such as those designated in HR950 as "Frontier Service Areas;" research, for example, should seek intensive, cost-effective services for areas where it is difficult to maintain program census levels.

- A second area is block grant funding. The annual block grant should be adequate enough and dependable enough to support the development of sustainable mental health and substance abuse services.

Some specific recommendations:

- restore the funding cut from state levels when the federal government shifted from categorical to block grants.
- provide real inflation-indexed annual adjustments.
- if set-asides and service development requirements are established as conditions of block grant funding, provide adequate increases to obviate the shifting of state support from one service sector to another; in the face of diminishing and shifting resources at federal and local levels, state government has a very difficult time providing and maintaining a stable and well developed service system.

- And a third area is financing:

  - the continuing inequities in third party reimbursement existing between physical health care on the one hand and mental health/substance abuse on the other should be redressed; both the amounts or reimbursement and the rules governing reimbursement qualification should be changed to accommodate and encourage both specialized and nonspecialized providers to develop the programs and provide the services so badly needed in rural areas.

This concludes my statement. I will do my best to answer any questions you may have, and I am looking forward to participating in the open discussion.

STATEMENT OF JOHN K. HANSEN, PRESIDENT, NEBRASKA FARMERS UNION

June 1, 1990 Fremont, Nebraska
To: Senate Appropriations Committee
Subject: The Future of Rural Health Care

The Nebraska Farmers Union works on a regular basis to help maintain and accelerate the availability of adequate health care for our rural residents. We work both on the state and national level. We salute Senators Kerrey and Daschele for making the effort to come to Nebraska to listen to the concerns of Nebraskans.

Specifically, we think that it would be helpful to wave the October 1 deadline for nursing homes that would require them to maintain full time registered nurses on duty at all times. We have both the cost and availability of registered nurses to consider. We need the flexibility to do the best that we can with what is possible. A partial loaf is better than no loaf at all. Many times the standards that apply in an urban setting with a financially sound economic base are not possible to meet in a rural setting with our present economic conditions.

Yes, we need to compensate rural hospitals at least the same rate as urban hospitals for Medicare. Yes, there are many things that can and should be done to help make rural health care both available and affordable.

The future of rural health care is contingent on the future of rural America, which is contingent on the Farm Bill and the economic conditions that it brings to rural America. It is a fact that the ten fastest growing poverty counties in Nebraska are all 100% rural counties. Our rural counties are facing growing poverty, declining populations, an ever increasing older average population, farm failures, business failures, and a climate of despair.

It is difficult under the best of situations to provide adequate and affordable health care to a geographically sparse rural residents. It is getting more difficult all the time as the gap between rural hospitals and the major hospitals grows. It is getting more difficult to recruit and maintain general practice physicians.

We ask you to not just send band aids, but rather look at the rural health care patient in a comprehensive problem solving way. The crisis in rural health care is here. It was brought here by national farm policies that are a disgrace, and that continue to treat rural people as second class citizens. Rural poverty is growing in lock step with all the problems that we associate with rural health care problems. We need economic justice for rural America first and foremost. To ignore the problems of inadequate farm income is to treat symptons instead of providing any real long term care.

Thank you.

STATEMENT OF JAMES D. NEUMAN

May 24, 1990

Junior Sen J. Robert Kerrey of Nebraska:
Here's my honest answer to your honest challenge in your May 21 letter reprinted on the opposite side:

I agree with Sidney M.D. Carl J. Cornelius, Jr., quoting the reason for the rural health care crisis: "GOVERNMENT."

How else can I explain the inconsistent reimbursements between Nebraska & Wyoming ? The areas are too similar for any other explanation than that of bureaucratic manipulation!
Can you? Don't try--just correct it!

Please, you & Sen Daschle, be bipartizan & have Virginia Smith or her staff representative at the June 3 meeting.

I have faith that MED & INSURANCE will also have much input.

I'm already in print. You should have it all in your file. For anyone else the complete pac is on file in Sidney Public Library.

I still stand like I did on August 28 when you were in Sidney: Just give all citizens tax deductions towards paying for our own health care. Of course these deductions should be for scholarships & any incentives that would return & preserve rural health care & caregivers.

All forms of gov't, as well as the other 3 corps in the MEDFLATION battle must work together.

Nationally & Internationally the goal is the same: WELLNESS SHOULD BE THE WATCHWORD OF OUR WORLD!

This independent voter-consumer would like to be in Scottsbluff for the June 3 meeting but Mom leaves the nursing home on Sundays for a home visit & that comes first.

So I cheer you all on with this letter.

FAITH, HOPE, LOVE, & REALISM!

Your MEDfly Neumantometer,

James

James D. Neuman
1934 Newton St.
Sidney,
N's B I G THIRD!,
Nebraska

LETTER FROM SENATOR KERREY

May 21, 1990

Mr. James Neuman
1934 Newton St.
Sidney, NE 69162

Dear James:

Senator Tom Daschle of South Dakota and I are planning two rural health care hearings in Nebraska in early June. The first is scheduled for Friday, June 1 from 3-4:30 pm at the Fremont Multi-Purpose Senior Center. The second is scheduled for Sunday, June 3 from 1:30-3 pm at the Panhandle Research and Extension Center Auditorium in Scottsbluff.

These are formal site hearings under the auspices of the Senate Finance and Appropriations Committees. Senator Daschle is a member of the Finance Committee's Medicare and Long Term Care Subcommittee, which has jurisdiction over a wide variety of health-related issues, including rural health. I will represent the Senate Appropriations' Agriculture Subcommittee which deals with rural and agricultural-related issues.

The theme of the hearing will be "The Future of Rural Health." Written testimony will be accepted and submitted to the full Committee. We would greatly appreciate your participation through written testimony on how Nebraska is addressing rural health care delivery and financing issues; how Congress can better assist in improving reform initiatives; how these initiatives could be used to address and improve health care in rural Nebraska.

I appreciate your assistance with this and look forward to a very interesting and informative hearing. If you have any questions, please don't hesitate to call Patricia Redel of my Nebraska staff at (308) 632-3595.

Sincerely,

Bob Kerrey

J. Robert Kerrey

LETTER FROM MARIANNE NIELSEN

June 1, 1990
Fremont, Nebr.

Marianne Nielsen
126 W. Charles St.
Valley, Nebraska

Thank you for giving ear to health problems.

I would like to address the apparent lack of concern for the patient under present health care in the United States. Through personal experience and first hand observation I see treating rules and regulations has become more important than the patients treatment.

If perchance a doctor would put the patient first and admit them for care not defined in the rule books (and they are thick) the doctor could be sanctioned with the hospital, who of course would not be reimbursed for services. This is critical to our local hospital.

Now, of course, not all regulatory laws are bad. But in my opinion and many others I have visited with, the Medicare pendulum has swung too far. In the meantime the patient suffers.

I have time to site only one example: Because Medicare, about four years ago declared pain, even of unknown cause and no matter how severe not worthy of even overnight observation and treatment, one is turned away without help. This can be more devastating than the ailment. Having insurance, does not open the door; for other insurance companies are following Medicare strategy. I still believe the doctor knows more about one's needs than an insurance company.

As retirees in our sixties and seventies and carrying insurance all of our life we had hoped to rest fairly secure in health services. Not so! We have always doctored in Fremont and happily so. In January of this year we were notified by Mutual of Omaha and Omaha Public Power that if we did not use the preferred doctors and hospitals we would pay an extra 10 percent with double deductibles where they apply. To comply we would need to drive twice as far to a hospital, in much more traffic and change doctors. It appears that the big ones are calling the shots and will soon gobble up the little ones.

I urge you to help the pendulum swing to the center where perhaps the patient may be considered. Peace of mind would be good preventive medicine; which by the way, insurance companies have not yet, adopted! We are grateful for the health coverage we have and pray that it will be there when needed. There are many fine hospitals in Nebraska we trust you can make them more accessible and affordable.

Questions: Is it true a percent has been cut from and designated for the reduction of the national debt? Can smaller hospitals like Fremont be expected to compete (serving a large area) with true expenses not recognized?

Yours truly,

Marianne Nielsen

STATEMENT OF MYLAN VANNEWKIRK, M.D.

I am Mylan R. VanNewkirk, an ophthalmologist practicing in rural Western Nebraska and Eastern Wyoming. I am pleased to address this committee of Senate Finance and Appropriations dealing with aspects of rural health. I would like to direct my comments to specific methods of rural health care delivery, and how Congress can better assist in improving reform initiatives.

OREGON TRAIL EYE CLINIC RURAL HEALTH CARE DELIVERY SYSTEM. I am a native of this area who was very attracted to medicine at a young age. I wished to live and practice my profession in this area and deliver the highest quality of sophisticated ophthalmic care. My clinic, the Oregon Trail Eye Clinic, has attracted two additional outstanding ophthalmologists. All of us are not only board certified ophthalmologists but are also fellowship trained subspecialists. We have tried to take our sophisticated skills to rural America, using a teamwork approach that consists of local family physicians, community and county hospitals and local optometrists. Our main clinic is located here in Scottsbluff, Nebraska. Our clinic is equipped with the most sophisticated diagnostic and treatment instrumentation available to modern ophthalmology. I have visited small state universities that actually have lesser instrumentation in their university clinics.

In addition, we offer our services through twelve regional community and county hospitals by providing outpatient clinics and outpatient surgery in these satellite locations. We have equipped a mobile surgical transporation system that provides the most sophisticated, modern ophthalmic surgical equipment to each of these community and county hospitals on a rotating basis. Duplicate and, in some cases, triplicate equipment is available in order to guard against technical problems during surgery.

This system allows services to be rendered near the patients' homes and saves a great deal of time for their families. It also increases utilization of the community and county hospitals in this region. The local physicians have been a tremendously important part of our team approach. I have developed, through the American Academy of Ophthalmology, continuing medical education programs that improve the knowledge and practice of primary eye care. These educational materials are utilized in continuing education courses at county medical society meetings, medical staff meetings and seminars to review and upgrade the local physicians' skills in primary eye care. With their general medical background and our supplemental educational activities, family practice specialists provide these communities with continual access to health care. Then our weekly visits to the satellite hospital clinics provide more complex levels of eye care services to these patients.

It is obvious from our continued increased patient load that our services are utilized, appreciated and needed.

MEDICAL EDUCATION. Medical Education is the life blood of health care delivery system. A reversal of the apparent decline in the number of applicants to medical schools is good news. In 1974 there were more than 42,600 applicants, however, in 1988 that number had decreased to 27,000. 1989, however, showed a .7% increase from 1988. Medical schools have made significant progress during the last two decades in attracting students from under-represented minorities. This must continue and emphasis should be placed on rural applicants who definitely are in the minority. The program designed by the University of Nebraska in cooperation with Chadron State College is certainly a step in the right direction. Rural America would especially benefit from a significant increase in the number of family practice residency programs provided in rural settings. Regional West Medical Center is an excellent site for a family practice residency program. The educational opportunities actually are superior in a regional referral medical center such as Regional West than compared to tertiary university settings which deal with highly complex sophisticated patient care such as liver transplantation at the University of Nebraska, where the family practice resident has significant competition among other speciality residency programs for the common patient problems. In rural settings they would have no other residency competition and would be able to have extensive hands on clinical experience, which is the time-honored and most effective medical education technique. It is alarming that the medical student graduate interest in primary care has decreased from 39.6% of the graduates in 1982 to 25.4% of the graduates in 1989. The primary care physician is the key to better rural health care. A team of other specialists, hospitals and other health care providers revolve around the primary care physician. I believe that establishing a family practice residency program in rural regional referral medical center such as Regional West would be an excellent way of bringing family practice physicians to our area and creating an understanding of our environment and culture that would motivate a significant percentage of those residents to live and practice in the rural regions.

HCFA AND MEDICARE REIMBURSEMENT DISCRIMINATION.
Our area physicians are consistently reimbursed at a lower level than physicians from all of our surrounding states. Since the government pays more for comparable services outside of our practice area, this lends the perception that these outside services are better. We continue to lose patients to outlying areas because of this misconception.

Current reimbursement formula actually costs Medicare more money because they provide for reimbursement at a higher level when the services are provided outside of the region. I am continually frustrated by the Medicare reimbursement system. Our citizens pay the same percentage into the system, however, they are discriminated against because services provided in this area are reimbursed at a lower level than any of the surrounding areas. Our citizens actually subsidize health care elsewhere. Certain physicians, hospitals and clinics operating in areas with higher reimbursement utilize this extra reimbursement to provide incentives for patients, for example, travel reimbursement. Congress should eliminate this reimbursement discrimination.

SUMMARY. It is possible to deliver sophisticated, modern, medical services in a rural setting, however, expanded services and continued improvement in health care delivery system must include incentives and mechanisms to improve the conditions of the family practice specialists. I feel there is uniform agreement among health care providers that we must stop the runaway American health care system expenditures. Many great financial savings and many health care benefits would result from improved primary care environment in rural settings. Health maintenance organizations which have lower health costs than other indemnity health care plans average 51.4% primary care physicians, whereas in the general indemnity plans, only 27% of the physicians function as primary care physicians. Primary care specialists skilled in handling common problems will refer fewer patients and admit fewer patients to the hospital and order fewer laboratory and diagnostic tests. Other specialists tend to practice high technology with over-reliance on expensive services which significantly increase health care costs.

Congress would do well creating an environment that would improve family practice medical education, especially in rural environments and would provide the public well by increasing the number of primary care physicians all over America as well as especially in this rural setting. Other specialists can work as team members in this health care delivery system providing the complex care not suited for the primary care physician. Other specialities should join ophthalmology in developing educational programs to increase the capability and skills of the primary care physician in common disorders dealing with that particular speciality. This would reduce referrals and expenditures.

Congress should initiate major rewards to its citizens who have developed and maintained good health care practices, or should penalize patients who voluntarily choose activities that are hazardous to their health and that greatly increase the health care expenditures, such as smoking.

In closing I would hope that other members of Congress have the same degree of interest as displayed by Senator Kerrey in gathering input from all health care providers, especially physicians, for development of reform initiatives.

The key to better rural health care revolves around the local family physicians and their teamwork relationships with other specialists. Certainly it is a great concern to see a smaller percentage of medical students choosing family practice today as compared to ten years ago.

I believe that establishing a family practice residency in the Regional West Medical Center complex and the surrounding community and county hospitals would be an excellent way of bringing family practice physicians to our area and creating an environment for them which would help them choose to practice in our region. Our regional referral center could easily develop a family practice residency program that would be superior to the typical university program where the family practice residents compete with all the other residents in their specialities.

Respectfully,

Mylan VanNewkirk

Mylan VanNewkirk, M.D.

LETTER FROM LEONARD FRODYMA, ADMINISTRATOR, OSMOND GENERAL HOSPITAL

June 1, 1990

The Honorable J. Robert Kerrey
U. S. Senate
7602 Pacific Street, Suite 205
Omaha Nebraska 68114

Dear Senator Kerry:

I have been the administrator of the rural hospital in Osmond Nebraska for twenty one years, and during these years, have enjoyed a great sense of pride in the growth and prosperity of our community hospital, our excellent reputation, our low cost and high activity, all due to our very stable physician staff consisting of three family practitioners, one from each of the towns of Osmond, Randolph and Wausa. We have enjoyed good economy of scale. This was a great place to grow... to raise a family... to be.

Even when the physician from Randolph announced after thirty four years his retirement two years ago, we were successful in recruiting an outstanding young man as a replacement, largely due to our reputation, even though it was a solo practice.

The when the physician from Wausa announced several months ago that he would be retiring in three to four years, plans for recruiting began, and a joint meeting was planned with the hospital board, a newly formed recruiting committee from Wausa and the Director of the Lincoln Family Practice Residency program.

The night before the meeting, the 62 year old physician from Wausa, R. L. Tollefson, died of a heart attack. Thirty six years of stable consistent medical practice in this rural community died with him!

Since that fateful evening four weeks ago, things have been in a turmoil. Major effort has been expended to recruit a replacement, yet to no avail. We are trying to remain optimistic, but many factors are against us getting a replacement as we were lucky enough to do two years ago.

Our two remaining physicians are temporarily filling in, and with the help of a physician's assistant we are planning to hire, we are hopeful that we can hold on until a full time physician is recruited.

Recent national figures show that for every physician coming out of the family practice residency program, there are one hundred openings. What are the odds of us attracting such an individual... to a rural, solo practice, to a community without its own hospital but one within 13 miles, to a community with very limited socially, culturally, or professionally stimulating activities, and to a rural practice where the physician will earn significantly less than his counterpart in the city due to the inequities of the reimbursement system?

We are as competitive financially as any other community presently recruiting, but even with the guarantees, the sign on bonuses, the relocating reimbursement, and the other perks, solo practice is not attractive. Most graduates are opting for partnerships, liberal time off, and sharing arrangements for call coverage. And finally, attitudes of the physician's wife can be the most significant reason for not choosing rural practice.

We can have the latest equipment, the best trained technical and nursing personnel, and the nicest house in the country, but unless we can find that unique individual that holds to the "country doctor" image of himself, and who is willing to sacrifice many of the factors most of us desire in today's way of living, we are in trouble. Many, many other rural hospitals in our small towns across the country are in exactly the same situation.

The writer of this morning's Omaha World Herald editorial, Dr. W. R. Schlichtemeier of Omaha stated the solution to this severe problem very appropriately. Resolving the significant differential between the rural and city physician reimbursement is the key ingredient to resolving the lack of desire, the lack of interest in the young physician going to the country to practice. We can turn this frightening situation around thru appropriate funding.

Within a seventy five mile area, there are now five fewer family practitioners than there were two months ago, one having died, and the other four being so frustrated with the system that they have moved to the city for an easier way of life. And what becomes of these communities and their patients? Where will the physician replacements come from? We are all competing for the few who will even consider a rural practice.

Our problems state-wide are growing more severe each day. Survival of many rural hospitals...already in jeopardy due to poor medicare reimbursement and lack of sufficient nursing and other professional personnel...is at stake. More hospitals will close; access to health care will grow more difficult.

I only hope that before it is too late, a solution will be found to the benefit of all the rural areas, or access to health care will become an even greater national problem.

What solutions do I offer? Nothing that has not already been much better stated. Help with incentives for the rural physician, along with the nurse and technician who agree to locate in the small communities. Better reimbursement for our physicians, and our hospitals who already have bitten the bullet more than in half! Easing of the regulations brought down on us from HCFA and the PRO; current regulations that emphasize improvement of our "quality of care"... our quality of care should be left to the judgment of our physicians, not the attorneys and reviewers miles away who determine quality by looking at the chart!

Let's try to make this complex labyrinth of health care simpler, to the financial gain of all. Ease off on regulations, reduce bureaucratic staff, reduce the cost of the endless of reviews presently underway, plaguing hospitals physicians, and nursing homes.

Senator, perhaps because you are a health care professional yourself, perhaps because you are a humanitarian with a great deal of understanding and vision of what this country needs to make it even greater, you offer us all hope for the future.

We appreciate what you have already done for us as our former Governor and now our Senator, and for all your efforts and leadership in Washington on behalf of health care for our country.

We must remain optimistic and united in our efforts to resolve these problems, and I am excited about your prospects for a better future.

God bless you for your dedicated efforts on behalf of all!

Very sincerely,

Leonard Frodyma

Leonard Frodyma
Administrator

STATEMENT OF RON ROSS, ADMINISTRATOR, CAMBRIDGE MEMORIAL HOSPITAL & HEALTH CENTER

Thank you Senator Kerry and Senator Daschle for giving us the opportunity to share with you our concerns about rural health care.

There is no doubt that we are approaching a critical period in our country's history as it pertains to quality, access and costs to all of us Americans. It is imperative that innovation, risk taking and down right yankee ingenuity come to the forefront to solve our staggering health issues.

With nearly 40 million Americans either noninsured or underinsured, access to health care is truly the key problem. As we have seen our farm economy dwindle in the '80s and see family health insurance premiums skyrocket to almost $400 per month, it is no wonder that rural health access is becoming extremely limited. Family incomes for most of rural Americans is small compared to their urban counterparts, and when we compare mortgages or rent, car payment, food, and the other necessities we find rural families, especially those 20-35 years of age, without the resources for health insurance.

Health care represents almost 12% of our gross national product. Truly we must all appreciate that this tremendous amount of resources should be sufficient to provide very good quality of care to all of us. However, there is a maldistribution of these resources which lies at the root of many of our problems. Although quality can be and is constantly challenged as to its definition, we must come to a conclusion as a society on what we expect and what we will tolerate.

Urban physicians who generate incomes of $5000, $10000 or more per day is a sin. Urban hospitals who have an average of $8000 or more per discharge compared to rural hospitals of $3000 per discharge (even when severity of cases is factored out) is a sin. Rural communities have been penalized since the early '80s because they kept their costs low. With DRG's and physician MAAC's based on historical costs, rural America did not have the fat to trim as the new reimbursement systems were implemented.

You and I must do everything within our power to see that we have primary physicians and other allied health professionals in rural America. The National Health Corp., even with its flaws, should be continued and improved.

Our country looks to you, our leaders, to come up with solutions and make decisions, even if they are not popular at the time. I believe that the time and energy you devote to meetings like this one, demonstrate that you two are truly leaders.

Since you are looking for ideas as well as expression of concerns, may I suggest that Congress appoint a task force of the key "players"; government, providers, insurance companies, education, business and consumers to come up with a plan, with a deadline of two years, to address and implement action. Congress must give this task force the authority to carry out their plan prior to its start. I might add that integrity be the main factor when considering the task force members.

Like our pioneering grandparents before us, let us look to courage, strength and wisdom as we plow ahead with vision and values.

Respectfully,
CAMBRIDGE MEMORIAL HOSPITAL & HEALTH CTR.
Ron Ross
Ron Ross, Administrator

STATEMENT OF M. THOMAS PERKINS, PH.D., A.C.S.W., DIRECTOR, REGION I MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

To The Honorable Tom Daschle and Robert Kerrey and members of the Senate Finance and Appropriations Committee:

I wish to thank you for this opportunity to share some information about one aspect of rural health care. Your interest in examining this subject is both appreciated and commendable.

Background:

As the Director or the Panhandle Mental Health Center I feel obliged to share both the good and the sad experiences in rural health care as it relates to those who suffer to some degree from mental illness. In my opinion, this is a subject which needs the scrutiny of people like yourselves, since you have the interest of rural needs at heart and the authority to highlight the gains that have been made and the problems which still need to be solved in rural health care.

Two years ago the American Psychiatric Association published a series of pamphlets entitled "Let's Talk Facts. . ." One of those publications focused on "Mental Illness: There Are a Lot of Troubled People." The average person would probably be surprised by the data found in this pamphlet. "At any given time, between 30 million and 45 million Americans - nearly one in five - suffer from a clearly diagnosable mental disorder involving a degree of incapacity that interferes with employment, attendance at school or daily life." (p.1)

In recent years we have turned our attention to the drama of substance abuse. There is no doubt in any sensitive person's mind that the abuse of drugs and alcohol has been costly and tragic. The media, education community, health care services, law enforcement agencies and all levels of government have pooled their resources to cope with an enemy far worse and more insidious than any we have had to deal with in the wars we have fought in this century.

Yet, it appears as though we have not mustered even one-half the energy or resources to fight the battle of mental illness which is just as costly and tragic as drug and alcohol abuse. "According to estimates by the Institute of Medicine, the direct costs of mental illness total $23.4 billion a year; the direct costs of substance abuse disorders come to $16.9 billion a year. . .) (p.3) It was reported in the same article that the combined indirect costs of mental and substance abuse disorders total $249 billion a year.

The tragedy of the situation is magnified by the fact that the majority of those needing treatment for their mental disorders either avoid seeking help or cannot afford to do so. Medical indigency is a growing problem in America. We are well aware that a large number of citizens cannot afford to purchase health insurance. "National estimates indicate that the percentage of nonelderly Americans with no health insurance increased from 13.9 percent in 1976 to 17.1 percent in 1984," according to R. G. Frank in the January, 1989 article entitled "The Medically Indigent Mentally Ill: Approaches to Financing," in the journal of Hospital and Community Psychiatry. In discussing medical indigency, Dr. Richard Frank noted that the problem is more prevalent among the mentally ill than among the population at large. Data from the National Hospital Discharge Survey conducted by the National Center for Health Statistics suggested that in 1986, 9.5 percent of psychiatric discharges had no insurance, compared with 7.6 percent of all patients. . . Data from the

National Institute of Mental Health suggest that 10.4 percent of discharges from general hospital psychiatric units, 5 percent of discharges from private psychiatric hospitals, and 62 percent of discharges from public mental hospitals were not insured in 1981."

Each one of us is aware of the fact that health care and health insurance costs are escalating at a rapid rate. Many Americans are having to make difficult decisions about their health care coverage. Some are choosing to discontinue purchasing health care coverage, even when they are aware of the risks. Employers are equally feeling overwhelmed by the rising cost of health insurance. The insurance rates jumped 46% at The Panhandle Mental Health Center this year. This only further emphasizes the plight of the mentally ill.

Many insurance carriers, including the "Blues" choose not to provide adequate coverage for the treatment of mental illness. It may be that they are well aware that one in five Americans suffer from a diagnosable mental illness and they choose not to accept the risk of providing adequate coverage in their policies. The reality is that the mentally ill are either not insured or underinsured and cannot afford treatment.

Hope for the Future:

Having shared these rather depressing statistics and comments, it is equally important to share some hopeful information. Perhaps in doing so you will have some positive information to share with your colleagues in Washington. There are two services that have started in Rural Western Nebraska which could serve as models for rural America. One is an Emergency Psychiatric Service; the other is a debriefing service for emergency personnel.

Emergency Psychiatric Service:

In 1988 the Nebraska Legislature passed the Nebraska Mental Health Commitment Act. In essence, the passage of this law decriminalizes dangerous, mentally ill behavior. It provides that after January 1, 1991, no person who is alleged to be dangerous and mentally ill can be put in jail for Emergency Protective Custody. Rather, the person must be retained in a hospital for an evaluation prior to a hearing by a Board of Mental Health. The law also mandates that counties with first class cities must contract with hospitals in those cities to provide emergency psychiatric care for the alleged dangerous and mentally ill patient.

One can guess that the cost will be great and the resources for such care in rural Nebraska will be limited. For example, I conducted a survey in the Fall of 1989 of the eleven counties in the Nebraska Panhandle which revealed that the cost of jailing a person ranged from $30 to $60 per day, while the cost of hospital care will range between $250 and $260 per day! These costs do not cover lab fees, physician charges, psychological testing or transportation. The law, which is well intentioned has presented a dilemma for rural counties whose financial resources are already limited.

Being aware of this, as Director of Region I Mental Health, I developed a plan, approved by the Governing Board, to contract with the hospitals in first class cities in the Panhandle on behalf of the eleven counties served by Region I. There are four such hospitals, one of which has declined to participate in the Emergency Psychiatric Service.

The eleven counties have agreed to pool some of their indigent health care funds, to match state funds, while the Region I Mental Health Services (which includes the Panhandle

Mental Health Center) puts up some non-tax funds for additional match. As a result the Region I Mental Health Services will do the following:

1. Agree to pay for up to seven days of hospital care for indigent patients who are alleged to be dangerous and mentally ill.
2. Train physicians and nursing service personnel in caring for and managing the alleged dangerous and mentally ill patient.
3. Train law enforcement officers, county attorneys and members of Mental Health Boards regarding the aspects of the Commitment Act and what the hospitals may be expected to do.
4. With state funds, construct and furnish four safety rooms in the participating hospitals, which will provide a secure environment for the alleged dangerous and mentally ill person.
5. The Panhandle Mental Health Center will provide consultation and evaluation services for physicians, hospitals, law enforcement agencies, county attorneys and mental health boards.

The Emergency Psychiatric Service which recently began its program offers a model of cooperation among state and county agencies, public and private health care services, mental health and law enforcement professionals, which has been outstanding. More importantly, it offers the alleged dangerous and mentally ill person a secure environment which will provide humane medical intervention until decisions can be made about what care can serve the best interest of the patient.

Critical Incident Stress Management:

As volunteer Director of the Nebraska Critical Incident Stress Debriefing program I would like to direct your attention to a most valuable but neglected group of people. These are people that every community must have, yet every community has taken for granted. Emergency responders, such as law enforcement, fire fighters, and emergency medical technicians provide a great service to their communities at immense personal risk and sacrifice.

In rural Nebraska fire fighters and E.M.T.'s are for the most part, volunteers. On the other hand, law enforcement agencies such as sheriff departments, local police departments, and state law enforcement services are all paid for their services. The exception to this rule would be those who are reserve or volunteer sheriff deputies.

When considering the risks with which emergency responders must contend it is important to note that while physical injury is always possible, responders must deal with the more subtle psychological injury as well.

In rural Nebraska emergency responders must always be prepared for the possibility that the next call they go on may include acquaintances, friends, or family. It is not unusual in rural areas for a responder to have to pick up dead and injured who are family members and friends. Neither should it be unusual for these committed men and women to experience normal stress symptoms to abnormal events such as deaths and injuries by fire, auto and industrial accident, self-inflicted wounds and injuries inflicted by others. One can deal with only so many deaths, broken and dismembered bodies, traumatized children and adults, before the effects of such stressful events begin to leave their marks upon emergency responders.

Those of us who live in rural Nebraska appreciate the fact that behind every police officer's badge, firefighter's gear, and Emergency Medical Technician's insignia is a caring humane man or woman, committed to promote public safety and health. We are also aware of the personal price that these people have paid in terms of depression, increased alcohol consumption, family disruption, and job attrition. It was for this reason that a Critical Incident Stress Management program was developed, first in the Panhandle of Nebraska, and subsequently throughout the state.

This volunteer service is designed to respond only to the needs of emergency personnel. Sponsored by four state agencies; Health Department, State Firemarshall's Office, Nebraska State Patrol, and the Department of Public institutions, the service is designed to meet the needs of men and women who have faced an unusual incident, i.e., multiple death or injury accidents, shoot outs, homicides, fires of unusual intensity, etc.

Trained mental health professionals and selected peers from law enforcement, fire and emergency medical services are volunteering their time to meet with and debrief those who have experienced an unusual event which has the potential for creating stress related symptoms. The volunteers are prepared to respond within 24 hours after a call for assistance has been initiated. To enhance this service, the State Patrol and Fire Marshall's Office provide the transportation for the debriefing team to the site where the debriefing takes place.

This is an aspect of health care which has been neglected. Men and women who have been debriefed, following a rather harrowing experience, have commented:

"Where were you ten years ago when we needed you?"

"It's good to know I can manage my stress."

"What a relief to know that I am not mentally ill!"
"It's helpful to realize that stress related symptoms are normal physical and psychological responses to abnormal events."

Emergency Psychiatric Services and Critical Incident Stress Management Services are two positive responses in rural health delivery. Each has been developed in spite of limited and scarce resources and with the cooperation of public and private agencies. Yet as the Senate considers health care delivery in rural America, please consider an infusion of Federal Funds to support and maintain creative programs such as these so that important services neither wither nor die.

The Reality:

As an administrator I realize that Senators and Congressional Representatives do not have an easy task. I recognize that local, state and federal resources are limited. There are legitimate, but competing claims made for the limited available federal funds. You must make painful decisions as you try to determine where the federal funds could provide the greatest support for the most pressing needs. I do not envy the position that you often find yourselves in when you have to deal with people like myself who try to make a case for special consideration.

Yet, please consider the following ideas. We in rural Nebraska try to be creative with our scarce resources. There is a limit as to what we can do without new or changed federal initiatives. Again let me cite some examples.

Public Community Mental Health Centers:

In rural Nebraska Community Mental Health Center's are often the only service available, and if there are private mental health providers, the medically indigent cannot afford to access their service. Further, it is not unusual for private providers to refer the mentally ill to a Community Mental Health Center when the client's insurance coverage has been used up.

In recent years, federal mental health funds have been tied to specific populations of the mentally ill, i.e., the homeless and the severely mentally ill and disabled person. Please recall that one in five Americans (including those who live in rural Nebraska) have a diagnosable mental illness and they are not homeless nor are they necessarily severely mentally ill.

When federal funds are tied to a specific population of the mentally ill, this limits the ability of rural Nebraskans who are acutely ill in obtaining needed mental health services. The Panhandle Mental Health Center, a public service, has not received an increase in funds for the acutely ill, who can benefit from outpatient psychiatric care, for at least five years. As far as it can be determined, federal and state funded mental health initiatives have been directed towards the homeless and the severely mentally ill and disabled persons. Is it possible that some persons would not be homeless or disabled had there been adequate mental health interventions early in their illness? It was only after their illness became tragic or dramatic that interventions become available. Please consider federal funding for earlier interventions.

Clozapine Treatment:

In recent years a medication has been developed for the patient who has not responded to the usual care of schizophrenia. Clozapine (better known as Clozaril) has produced rather dramatic results in a small population of patients whose illness has been treatment resistant. The results for some have been rather dramatic such as

Granted there are some rather dangerous side effects. Because of this those patients who elect to take Clozaril must be carefully monitored, which includes a weekly blood screen. One can imagine that the cost for such a treatment will be high. Some estimate the cost in excess of $700 per month! This is a treatment which must be considered to last a life time, in much the same way that a diabetic has to rely upon insulin.

The medical staff of the Panhandle Mental Health Center has identified several patients who it is believed could benefit from treatment with Clozaril. The problem is that there are not any who could afford the $700 a month or $8,400 a year to take advantage of this treatment. (One should note that this cost is much less than institutionalization.)

Our staff is prepared to provide the monitoring and support to assist in the management and care of patients who have been prescribed this medication. We ask that our patients be given access to Clozaril and a chance for a near normal life with assistance through federally funded projects. Federal assistance through the auspices of the National Institute of Mental Health could assist a special group of people in becoming productive, self-supporting citizens.

Professional Resources:

A little over five years ago the two staff psychiatrists left the Panhandle Mental Health Center for private practice. Realizing that not all of our patients could afford the $90-

$110 an hour for private psychiatric care, we began a search for a psychiatrist to work in our agency. In August of last year, we were finally able to secure the services of Dr. Allen Kirk, a psychiatrist trained through the assistance of the National Health Service Corp, a federally sponsored program.

The gratitude which I feel will never come close to that which our patients feel because of the competent psychiatric care to which they now have access. Personally, the National Health Service Corp is worth more than its weight in gold. Yet, like other important services it too is underfunded.

Rural Nebraska needs competent mental health professionals committed to serve in underpopulated areas. The National Health Service Corp in past years has been a resource through which professionals are matched with areas having the greatest need. This valuable resource is in need of a tremendous infusion of federal support so that it can continue to provide training for health care professionals.

Attached you will find some data taken from a study which I completed last year. The study compares the distribution of physicians, psychiatrists, psychologists and social workers by county and mental health region. The results are not unexpected.

Regions V and VI, which include Omaha (Douglas County), and Lincoln (Lancaster County), have a greater percentage of health care professionals based on population than do rural regions such as I and II which include Scottsbluff (Scotts Bluff County), and North Platte (Lincoln County). For example, Douglas County (Omaha), Lancaster County (Lincoln), and Sarpy County (Papillion), contain an estimated 44.1% of the state's population and have 72.3% of the state's practicing physicians. The Nebraska Department of Health reported that in 1986 there were 114 psychiatrists in Nebraska, 100 of whom were in Douglas and Lancaster Counties. The remaining 14 were scattered throughout Nebraska.

Many are aware that rural America in general, and rural Nebraska in particular is experiencing a shortage of health care professionals and as a result all are in crisis. In my opinion there is no service finer than the National Health Service Corps. It has provided skilled and caring health professionals to rural America and Nebraska. I would urge that this resource be considered a top priority as a means to helping rural citizens gain access to necessary health services.

Conclusion:

The fact that you have had this hearing in Scottsbluff gives people like myself hope that someday rural Nebraska will have a well developed and managed health care system. Your interest and concern can only lead to positive results.

May I ask that as you consider rural needs you consider that the needs of people in the Plains States will be different than the needs of those in rural New York? As you consider this, please develop a system, or priority status, for rural states so that the more populated states do not take the "lion's share" of funds and services which you propose.

Thank you for this opportunity to share these observations with you. Please feel free to contact me for clarification of these statements or for any assistance which you feel I can offer.

County Distribution of Physicians

Needless to say, the greater distribution of hospital and physician resources will be found in Lincoln and Omaha. In all fairness, these numbers may be skewed as they do not give a complete picture of the location of all the hospitals or physicians in the state. However, the "Nebraska Health Manpower Report does substantiate the claim about the distribution of physicians: "In 1986, the metropolitan _counties_ of Douglas (Omaha), Lancaster (Lincoln), and Sarpy (Papillion), contained an estimated 44.1% of the state's estimated population, but they contained 72.3% of the state's practicing physicians.

Secondary population centers, _counties_ containing cities with over 10,000 residents were estimated to contain an additional 21.6% of the population and 16.3% of the active physicians in 1986. Out of the remaining 79 counties, 19 were without an active physician. Although these 19 counties are sparsely populated, they did contain an aggregate estimated population of 41,541. The other 60 counties contain 31.7% of the population and only 11.4% of the practicing physicians." (p. 5)

Table 10

Psychiatrists by Region

Region	Population	Psychiatrists Per Region
Region I	97,700	2 *
Region II	90,500	1

Region III		215,400		8
Region IV		219,100		3
Region V		394,700		20
Region VI		562,500		80
TOTAL:	-	1,579,900	-	114

* In 1989, one psychiatrist was added to Region I, psychiatrist per population is now 32,566.60.

Psychiatrist(s) by Region

In 1986, it was reported that there were 114 psychiatrists in Nebraska, 100 of whom were in Douglas and Lancaster counties. The remaining fourteen were scattered throughout Nebraska. Fourteen psychiatrists are providing services to seventy-two of the ninety-three counties with a population base of 622,700, 39.4% of the state's population.

This means that there is one psychiatrist for each 44,478 population. In Region I, with the addition of a third psychiatrist in 1989, there is one psychiatrist for each of 32,566 population. A further look at the psychiatrist per population ratios indicates that Region III has the best ratio of any of the rural areas with 1: 26925. Region V has a 1:19735 ratio, while Region VI enjoys the best ratio of all with a 1:7031. Region II has the worst ratio of all the Regions with a 1:90500.

While the study is aimed at a review of the psychiatric resources available in Region I, a broader picture would reveal that there is a disparity of such resources between the identified four rural regions and

Region V and VI, which contain the largest population base and the greater number of psychiatrists (957,200: 100, or 1:9572).

Table 11

Psychologists, Certified Master Social Workers, Certified Social Workers by Region

Region	Population	Psychologists	Certified Master Social Worker	Certified Social Worker
I	97,700	3	10	39
II	90,500	4	4	41
III	215,400	24	26	103
IV	219,100	14	13	69
V	394,700	101	110	305
VI	562,500	106	241	263
Total:	1,579,900	252	404	820

Data regarding the number of Psychologists, Certified Master Social Workers, and Certified Social Workers was supplied by the Department of Health, Bureau of Examining Boards.

Table 12

Psychologists, Certified Master Social Workers, Certified Social Workers Per 100,000 Population

Region	Psychologists Per 100,000	Certified Master Social Worker Per 100,000	Certified Social Worker Per 100,000
I	3	10	39
II	4	4	41
III	11.14	12	47.81
IV	6.38	5.93	31.49
V	25.58	27.86	77.27
VI	18.84	42.84	46.75

Licensed Psychologists

Data from the State Health Department reveals that there are 252 licensed psychologists in the state. The data does not differentiate between Masters and Ph.D. Clinical Psychologists. What it does indicate is that Region I has the least number of psychologists (three), while Region VI has 106. However, if one were to analyze the data by comparing it with a population such as units of 100,000; Region V fares better than any Region as it has 25.58 psychologists per 100,000. Again, Region I continues to be in last place in this category.

Certified Master Social Workers

Similar data was also obtained from the State Health Department in regards to Certified Master Social

Workers. This is a fairly new category of state certified professionals and represents a social worker with a Master of Social Work degree from an accredited college of social work with a specified number of hours of supervised practice. Region I is not rated last in this category as there are ten Certified Master Social Workers compared with Region II which has only four and is rated last in this category.

Region VI has the greatest number of Certified Master Social Workers of any of the Regions with 241, and it has the best ratio of Certified Master Social Workers per 100,000 population at 42.84:100,000. It is interesting to note that Region IV has 13 Certified Master Social Workers compared to Regions I and II with ten and four, respectively. However, with its population base, Region IV ranks fifth among the other Regions in the number of Certified Master Social Workers per 100,000 population, 5.93:100,000.

Certified Social Workers

In addition to the Certified Master Social Workers, Nebraska also has a category described as Certified Social Worker. This generally represents a Bachelor's level Social Worker with experience, or a Masters level Social Worker without the requisite experience to qualify for the higher level of certification. The data from the State Health Department indicates that Region I has the least number of Certified Social Workers of all the Regions, but when compared on a population basis, Region IV has the lowest number of Certified Social

Workers per 100,000 at 31.49:100,000. Region V ranks first in actual numbers of Certified Social Workers with a ratio of 77.27:100,000.

Professional Human Service Resource Assessment

The value of this human service professional resource assessment lies in the fact that it is another way in which one may demonstrate that rural Nebraska, when compared with the two Regions which have metropolitan cities, continues to experience deficits. When comparing the totals, Regions I through IV with _either_ of the remaining two Regions, the comparison reveals that Region V or VI by themselves have more psychologists, Certified Master Social Workers, or Certified Social Workers than the others. It should be noted that Regions I through IV have a combined population of 622,700, while the combined population of Regions V and VI is 957,200, or 60.58 per cent of the state. Yet Regions V and VI have 82.14 per cent of the psychologists, 86.88 percent of the Certified Master Social Workers, and 69.26 percent of the Certified Social Workers.

Among the conclusions which one can draw is that as in other categories of professional human service workers, the more densely populated Regions enjoy a greater share of the resources when compared to rural Regions of Nebraska. For example, the psychologist ratio on a statewide basis is 15.95 per 100,000. Region V has a ratio of 25.58 and Region VI has a ratio of 18.84. A similar comparison of Certified Master Social

Workers based on a state population of 1,579,900 indicated there is a ratio of 25.57 Certified Master Social Workers per 100,000. Region V falls within the range of that ratio with 27.86:100,000 Certified Master Social Workers while Region VI exceeds the ratio by 42.84:100,000.

When considering the ratio of Certified Social Workers on a statewide basis, there are 5.19 per 100,000. Region V's ratio is considerably higher than the state's average at 77.27:100,000. Region III fares some better than Region V1 with a 47.81:100,000 compared to 46.75:100,000 respectively.

While time does not allow for a research of the data which would reveal why the Regions with the larger numbers of population have a greater wealth of human service professionals, there may be some variables worth investigating such as: making a comparison of salaries of professional human service workers among the Regions; the value of being close to universities or colleges in one's field; the importance of clustering of professionals for purposes of consultation and support; and the influence which one's university may have had on determining whether or not one would have chosen a rural practice over a city practice.

STATEMENT WENDY L. ASMUS, R.N., DIRECTOR, HOME CARE/COMMUNITY HEALTH SERVICES, REGIONAL WEST MEDICAL CENTER

From my perspective as the Director of a Rural Hospital based Home Health Agency, the area that is most alarming is the growing care gap among the elderly, the chronically ill and the handicapped.

The principle that the ability to pay should have nothing to do with the access to the highest quality of health care available was central to the enactment of Medicare, however at the present time service gaps remain in the health care system. These gaps would seem to be even wider than at any time since the enactment of Medicare system.

For example:

-Many children with birth defects or related chronic medical problems are unable to obtain needed care, or are becoming unnecessarily institutionalized.

-The Medicare program covers only about 38-40% of health care expenditures of elderly residents of Nebraska. There is no coverage for hearing aids, dental care, eyeglasses, prescription drugs, and extremely limited coverage for Home Health Care with virtually no coverage for long-term care.

-Coverage for the disabled is available but the "definition" of disability is so limited that very few individuals can qualify.

-According to NCHSR (National Center For Health Services Research Technology Assessment) - "Uninsured Americans: a 1987 Profile"; 37 million Americans were uninsured at the beginning of 1987. Among those include workers employed in industries charactarized by seasonal employment, self employment, or less skilled, less technical work force (including agriculture, construction, and sales, as well as repair, and personal services). Employees of small firms and their dependents are also less likely to have employment related coverage and are at greater risk of being uninsured than employees of large establishments more common in urban areas.

The one area that is of greatest concern is long-term care. The fastest growing age group in America is that over age 85. Statistics show that rural areas have some of the highest oldest populations in the country. Americans who live to age 85 and beyond inevitably suffer from chronic disabilities. These problems tend to be complex and chronic in nature. As more and more individuals reach this age group, the need for long-term care will become more and more acute.

At present the system of health care is directed towards acute care. The American policy towards long-term chronic care is one of neglect or abandonment. The only current answer to long term chronic care is nursing home placement which is only available to the very wealthy, who can pay privately, or the poor who have exhausted their assets and are willing to take the paupers oath and become wards of the State.

Many Home Health Agencies do provide long-term care but resultant increasing pressures of rising health care costs and the pressure of cost containment make it extremely difficult to do so. Persons needing chronic home care cannot even receive acute home care because they are determined to need more care than merely "intermittant" care.

Examples of current cost containment pressures:

-Some persons are receiving no health care at all.

-Individuals are receiving reimburseable acute inpatient hospital care but are leaving hospitals "sicker and quicker" with either no home follow-up or limited follow-up care available. Some are "too sick" to qualify for the limited Medicare benefit and are either readmitted to the hospital, or to a nursing home.

-Individuals must depend upon family members for care which puts a burden on the family.

The current restrictions imposed by Medicare in coverage and reimbursement issues are a prime example of the gap in needed health care.

The Home Care portion of Medicare represents only 2.4% of total Medicare expenditures, yet home care is one of the fastest growing components of the Medicare program. The increasing aging population, the need for chronic long term care versus acute care and reduced length of hospital stays as a result of the Prospective Payment System has led to a dramatic increase in the demand for home care services. While the demand for service has increased, the actual use of the home care Medicare benefit has in fact declined due to the various regulatory moves on the part of HCFA including claims denials, eligibility criteria and inconsistent interpretation of the Medicare regulations.

The red tape and paperwork with which agencies must comply in order to obtain reimbursement has increased tremendously. Agencies must submit huge amounts of documentation which only results in increased costs to the agency. Home Care Agencies are drowning in paperwork. To submit a Home Care claim for $30,000, a Home Health Agency has to submit 279 pieces of paper; for the same claim, hospitals have to submit one piece of paper. (This was researched by Bob Parker, National Home Care Board Member). Identified as problem areas are duplication of information on the clinical patient record and HCFA form 486, the excessive amount of detail demanded and frequent changes in forms and completion instructions.

Home Health expenditures constitute a very small percentage of either Medicare or Medicaid Programs. In 1984, Americans spent $387.4 billion for health care: $258 billion was for hospital care, $32 billion for nursing home care and only $3.3 billion for Home Care as compared to either of the above.

Utilization of Home Care represents a cost savings of approximately 50% as compared to institutional care. Home Care represents a fraction of the cost of hospital care. The use of Home Care can result in major cost savings to the patient and to Medicare.

In addition to acute and chronic care populations, there are other populations which have limited, if any access to Home Care.

One major category is the under 65 years of age population. Medicare does not cover persons under 65 years of age and the limited Medicaid Home Care benefit applies to only those who qualify on a limited basis. Private insurance provide limited acute home care coverage and it is usually equivalent to Medicare coverage, or less. This is despite a demonstrated need for home care.

There are also limited access to and limited payment sources available for even acute home care for Veterans, and American Indians (comprising a significant population in Western Nebraska), as well as certain other minority groups. In addition AIDS patients have little, if any access to reimburseable home care services.

Present estimates are that 1.5 million Americans and 5-10 million persons in the world are currently infected with HIV. The Institute of Medicine and The National Academy of Sciences predict that there will be 196,000 cumulative cases by the beginning of 1991, 71,000 patients will be alive at the beginning of the year, 74,000 new cases will be detected during the year, and 54,000 patients will die of this infection during that year. The current projections are that the medical care cost for AIDS in the U.S. in 1991, will be $8 - $16 billion, not considering the rather sizable bill for health care needs of patients with other conditions within the spectum of HIV infection.

Considering the nature of this disease, a coordinated plan of care should have home care services at its core, involving the hospital for acute needs and adding additional services as needed.

Average hospital cost per day is approximately $500.00. Intensive care can drive the cost up to $1,500.00. Home care programs are viewed as being the best equipped to provide alternative care for AIDS patients at this time, as well as least costly.

Rural Nebraska is certainly not exempt from facing the issue of AIDS. The limited experience this agency has had in caring for AIDS patients is that there are no support groups, special help groups or assistance programs for the AIDS patient in our non-urban area. There are virtually no sources of reimbursement for medications, or home care for the AIDS patient who does not have the ability to pay. Medicaid has proven to be of extremely limited help and the red tape involved in seeking payment is incredible.

The question of how to best provide and pay for long-term chronic care that would meet the needs of the aging as well as chronically ill population needs to be addressed. The appropriate roles of the private and public sectors in long-term care financing must be determined based upon which approach provides the best system of providing long-term chronic care. Although numerous bills have been introduced to congress to resolve the critical problems of long-term care, it is only through a universal social insurance approach that the risk of long-term care can be pooled across the entire population minimizing per capita costs and containing administrative and marketing costs so that the vast majority of resources allocated can be spent on direct services with emphasis on Home Care.

STATEMENT OF JOAN CROMER, EXECUTIVE DIRECTOR, PANHANDLE COMMUNITY SERVICES

CONCERNS:

1. Access to Health Care

   a. Lack of Providers: aggravated by lower Medicaid reimbursement rate in Nebraska

   lack of professional job opportunities and/or availability of higher education for spouses of doctors in rural communities

   b. Increased problem to low income families because, of those doctors who will see Medicaid patients, many are limiting new clients to one (two local physicians) or two (another clinic) per month. Those clinics who have traditionally seen Medicaid patients are saying "enough"--"this should be shared by other physicians, so we will see no more."

   c. Because of the shortage and the necessity to wait from several days to several weeks for an appointment, "paying" clients go out of town (ie. Fort Collins, CO.). This leaves local physicians with a higher percentage of the low income, including Medicaid patients, resulting in still lower net incomes. The "Catch 22" is that this professional then leaves the community, creating an even greater shortage of professionals.

B. Lack of Finances/Programs/Insurance:

   a. Data from our local Head Start program which includes 225 children (218 families) includes the following information:

   30 Families had private health insurance (the largest number yet recorded - but less than 14% of the total families

   89 Families indicated they were eligible for Medicaid reimbursement; actual reimbursement covered only 74

   114 Families (considering actual reimbursement) had no health insurance and lacked the funds for appropriate care --as they met OMB income guidelines

   Only two of the 218 families had dental insurance. The local Head Start program spent $16,000 from its limited budget to pay for dental services beyond reimbursement received from Medicaid, even though the local State Dental clinic facilities were used and clinic settings were utilized as much as possible.

   b. The need for increased funding for Maternal Child Programs is imperative. Client numbers in our local program have increased over 50% in the past two years, yet the budget increased by approximately 2 1/1%. This had to cover a 20% increase in staff salaries. The Maternal Child Health Programs have proven that they can provide a very significant financial savings related to the cost of low-birth weight babies and infant mortality rates.

   c. In Nebraska, and in some other states, the age limit for which Medicaid will pay for tubal ligations is 21. Recently we have seen two young women for whom this has created a problem. One is now 20, and delivered her third baby in Washington state so that she could have a tubal ligation. The other client is age 19 and expecting her third baby in July. (One of our staff worked in South Dakota where she had as a client a young woman, incest victim, who had 4 babies, fathered by her father, who were all deaf.)

SUGGESTED SOLUTIONS:

1. Equitable rate of Medicaid Reimbursement
2. Recognition of role of allied health services, and increased scope of Nursing practice:
   - a. Increased use of Physician Assistants and Nurse Practitioners (which will necessitate changing some state laws to allow opportunities, especially for nurse practitioners)
   - b. Provide for training opportunities for Family Practice Residents in rural communities (Scottsbluff had one resident (slot) for the past two years - but is now deemed as too large a community as smaller towns have even greater needs.
3. Resolution of high costs of liability insurance for health professionals.
4. Consider the economy of delivery of health care in mass settings. Even though it may not be the most desirable, it does provide the service at a lesser cost. Most recently our agency has experienced this through the management of the Migrant Health Clinics. It has been estimated that in our Head Start program, we have experienced a savings of 1/3 to 1/2 through the use of the mass clinic approach.

PANHANDLE COMMUNITY SERVICES thanks you for this opportunity to express our concerns, and share some of our suggestions.

WIC COMMENTS/CONCERNS:

WIC is another program, preventative in nature, which has resulted in considerable economic savings across the country by providing nutrition services to pregnant and lactating mothers and their infants.

However, local agencies are being presented with an impossible management situation, as they are asked to increase numbers of persons served, and again limited to 1 1/2% - 2 1/2% administrative costs. This does not keep up with the cost of living, particularly in the area of salaries of health care professionals. In our own program, WIC nurses and dietitian are at least 25% below the salary of comparable positions in the community. The Community Action Agency absorbs some of these costs. In addition, our WIC Director does private consulting at Nursing Homes and teaching at the college with income from these endeavors going to support the program.

WIC Director, Betty Kenyon, is also concerned about the whole "Rebate" approach. It has resulted in an increase of formula costs to the entire population. In some states, mothers have not been allowed a choice as to the type of formula. In some major hospitals bordering on two states, who have decided to have "sole source" providers, it has created a management "nightmare". Staff at the hospitals having to inquire as to the type of formula allowed by the state and starting the baby on that formula before leaving the hospital.

It is important that client numbers be increased, but this can only be done as administrative funds are provided to enable a quality program.

STATEMENT OF BARBARA ROPP, R.N., DIRECTOR, HEALTH SERVICES, PANHANDLE COMMUNITY SERVICES

To Senate Appropriations Committee
In Scottsbluff, Nebraska
June 3, 1990
From Barbara Ropp RN, BSN, Director Health Services,
Panhandle Community Services, involving Maternal Child
Health Project, Family Planning, Migrant Health

Thank you for expressing your interest in our local situation by being here and receiving statements from us.

One of the problems I see is the accessibility of health care. We have a shortage of nurses and physicians, especially those involved in primary care. Newcomers to our community find it difficult to find a family doctor regardless of their ability to pay or their payment source. The emergency room is not an efficient provider of primary care and yet that has to be my recommendation when someone calls me for help to find a doctor for an acute problem. Nurse practioners and physician assistants could be useful but in a litigious climate physicians have difficulty assuming responsibility for such providers.

Money, is of course, the bottom line. In my work, there is not enough of it. As a grant funded operator, we are constantly asked to do more without receiving more funding; the pressure on staff is great. If we are truly serious about issues such as prenatal care, then fund us to do the job. Lower rate of medicaid reimbursement to rural areas is an issue with which you have to be familiar. Succinctly the rural-urban medicaid/medicare payment descrepancy is not fair.

Rural citizens are entitled to availability of quality medical care; nurse practioners and physician assistants will have a role, but there must also be quality physicians present. Urban people may feel untouched by the rural problem at present, but like spreading ripples the effect of the rural problem will impact care in all parts of our country. The rural health care crisis must be solved cooperatively.

Thank you for once again coming to western Nebraska and listening to our concerns. There is a crisis in delivery of health care in rural areas.

In my role as Director of Health Services at Panhandle Community Services involving Maternal Child Health, Migrant Health Services, and Family Planning, the daily problems involve inadequate funding to deliver needed services and adequately pay staff coupled with difficulty in recruiting enough nurses and physicians to deliver those services.

As a physician's wife, the discrepancies between Medicaid reimbursement between rural and urban areas complicates attracting new partners and has a deterimental affect on our hospital.

STATEMENT OF QUIKARE MEDICAL CLAIMS FILING

I've picked only a couple of items for the purpose of bringing to light how it is from the bottom looking up, perhaps the "people's" point of view. Hopefully this perception might assist you in determining feasibility of revamping the Medicare program.

Care has been taken through the years to equalize gas prices, grocery costs, transportation expenses - most of the basics of life. Medical care should be next. What is the connection between wage index and cost of medical care? Why is medical care in one area of the nation worth more than care, just as qualified, in a different part of the nation? The basic remains that medical care is needed everywhere. Wouldn't you rather be minutes, in lieu of hours, away from medical care if critically ill?

All medical care could be reimbursed by Medicare equally through implementation of a nationwide list of care indicating a set dollar reimbursement applicable to everyone. Much time and money has been spent in formula equations producing the values of our medical care, so the making of such a list should come from that experience. The detail might well come from the procedural codes already in existence. Such a listing will accomplish two things, simplification and equalization. I see no reason this cannot happen since changes have been occurring down through the years when HCFA so decrees. One of the latest decrees will be the "lid" controls to be imposed upon our medical providers. Are such "lids" imposed upon lawyers, corporate executives, etc.?

Another decree effective January 1990 is the automatic crossover of the Medicare Explanation of Benefit to the supplementary insurance company's claim payment to the beneficiary. This has not been done in the past, why is Medicare now attempting this? Supposedly to assist the beneficiaries!?!? Confusion stems from the paper shuffle to the beneficiary because:

> Numerous insurance companies require itemized bills and/or completed claim forms that are not provided by Medicare
>
> People change insurances frequently in this age bracket overlooking the fact others need to know of the change
>
> Beneficiaries have no constant process to rely on since this crossover stems from participating providers required to submit the necssary information to Medicare, and not all providers are participating. When illness occurs usually three or more providers are involved with each exercising their own assignment preference.

Some, and at this point the minority, claims do crossover smoothly; however, bear in mind most have added paper maze to an already confusing pile of papers!

Medicare could dispense with this phase of their operation, eliminating some administrative costs, eliminating partial burden from medical providers and simplifying an already too cumbersome program. I feel this attitude could prevail with several areas of the Medicare program. Perhaps we should let people take care of people more, not relying on, or expecting the government to cover everything.

LETTER FROM PAUL PHILLIPS, M.D.

Dear Senator Kerrey,

I would like to make a suggestion or two which I think could save money and improve medical care.

1. Remove some absurdities from our system:

a. Correct the vast disparities in physician compensation such as ophthalmologists making $800,000/year while the family physician earns $50,000/year. A Nebraska physician with the exactly similar education and experience may earn half what the California, Florida, or New York physician makes.

b. The most wealthy of our population, those over age 65, getting free health care. That's absurd. Dump Medicare and give free health care, or more appropriately, reduced-cost care to those who really need it.

c. Apply constraints to pharmaceuticals and other medical suppliers who make what appear to be massive overcharges (e.g., orthopedic implant manufacturers charge $4,000 to $5,000 for a small piece of metal and plastic for hip replacements).

d. Alcohol is thought of as food in this country and is advertised as healthy and desirable. That's absurd. Alcohol is by far the worst drug we deal with. We can in no way deal with the other bad drugs effectively if we don't treat alcohol with the honesty it deserves. Fetal alcohol destroys the next generation.

e. Stop the manufacture of cigarettes!

f. Close the Veterans Administration Hospital system. They are outrageously expensive and the laughing stock of the medical community. Give vouchers to veterans to get their care through the mainstream system.

g. High tech, modern medical care is too expensive and uses valuable resources at the wrong end of human life. Coronary bypasses, cataracts, total joints, organ transplants, AIDS care and some others should be only partially funded by government and then only on a needs-based formula. Cost control requires some rationing.

h. Malpractice, its absurd, we can't hold doctors to unattainable standards of perfection. Humans must make errors, that's the way we are put together. Patients should be compensated to the exact and honest cost of the error on a no-fault basis determined by a specifically appointed citizens commission. The offending physician must be evaluated for his ability to continue medical practice. The lawyers and the insurance companies now rake off about 75 cents of the malpractice premium dollar while the injured patient gets 25 cents. That's crazy.

i. Society has lost a generation of urban black kids, worse than that, the rest of society will be required to support them. The Great Society programs have destroyed their initiative, alcohol and other drugs have destroyed their minds, apathy and having no one who cares about them or has any interest whether they live or die has arrested their character development. We need to show those kids that we are interested in them. Maybe we could farm them out to agriculture and other families throughout rural America. The cost of not doing so is unbearable.

2. Having dealt with the above aberrations in the system one must be careful not to make up new ones.

Don't socialize the system. People simply will not give their best effort under socialized systems. Everyone loses. Socialism can't survive the truths and realities of human nature. Implement socialism and you will have a poor effort and a poor product. We must be our "brother's keeper" but we must do it in the win-win mode.

Thanks for your ear.

Sincerely,

Paul Phillips, M.D.

LETTER FROM SHAUNA LIPSACK, DIRECTOR OF PHYSICIAN RELATIONS, REGIONAL WEST MEDICAL CENTER

Senator Robert Kerrey, Nebraska
Senator Tom Daschle, South Dakota
United States Senate
Washington, D.C. 20510

Dear Senators Kerrey and Daschle:

The rural physicians of Nebraska are extremely grateful for your concern related to rural health care issues. Your leadership in scheduling public hearings on rural health care in our state is commendable.

In my work at Regional West Medical Center I spend the majority of my time recruiting physicians to practice their honorable profession in numerous locations throughout the 11 counties of the Nebraska panhandle. The complexities and frustrations of my task are numerous and not different from those facing physicians.

Within the last two years, Scottsbluff and the surrounding area within a 15 mile radius has lost 7 family practitioners that have not been replaced. My hope that they will be is becoming diminished rapidly. As a result the numbers of patients needing a physician are growing and these are not just patients who have a reputation for abusing the system, but outstanding citizens as well. The emergency department volumes have risen drastically as a result. This cannot and does not replace the importance of having ones own family physician.

The problems are numerous, however, there is no question that a big factor is that Nebraska's rural physicians are being underpaid by Medicare. The most talked about solution today is the Resource Based Value System that was passed by Congress last year. This program alone will not meet the needs of rural Nebraska. Looking at the estimates of the impact of the RBVS program, one can see why rural physicians are not satisfied with it. If mandatory assignment passes in 1992, the non-participating physician in 1989 will take home less money in 1992. Even if Senator Robert Packwoods "Rural Health Improvement Act" passes, the participating physician in 1992 will be paid less than his average colleague was paid in 1989. Rural Nebraska is at an approximate 60% floor. This is 40% less than the national average. A 66% raise is needed to get back to the national average.

To achieve equity in Medicare reimbursement the percentage mathematics of the RBVS must be tempered with a convergent floor and ceiling. The AMA, the PPEC and the National Rural Health Advisory Committee all agree that raising the floor is a possible solution. In fact a raised floor combined with the RBVS holds the best opportunity for rural Nebraska to obtain parity.

I ask that you support Senator Packwood's "Rural Health Improvement Acr" and sponsor legislation to raise the prevailing charge floor for primary care services to 80% of the estimated national average prevailing charge.

To keep physicians in rural Nebraska and to successfully recruit new ones, we have to offer at least an average wage. Rural nebraskans desperately need those physicians.

Sincerely yours,

Shauna Libsack

Shauna Libsack

LETTER FROM JANE PARKS, LIFELINE SPECIALIST, REGIONAL WEST MEDICAL CENTER

Since I am the Lifeline Specialist at Regional West Medical Center in Scottsbluff, Nebraska, I am quite concerned with healthcare issues and implications for rural Nebraska.

The average age of most of my Lifeline subscribers is 80-85 years. Many of them have a low income and have medical problems which require quite a bit of treatment. Many of them have commented that sometimes they have to decide whether to eat that day or take their medications. This is a situation which could be life-threatening.

Since the inception of the Lifeline program at Regional West in 1985, we have found many people who are medically at risk but who cannot afford the small monthly fee that we charge for monitoring the equipment. The individuals who started the program established a fund to help those persons who needed the service, but could not afford the fee. The fund has been supplemented through employee donations, donations from organizations and fund-raisers. We have also been fortunate to receive funding from the Aging Office of Western Nebraska. Currently we are helping 27 people with either all or a portion of the monthly fee.

Last fall, I did attempt to obtain some funding from the Medicaid program. Almost all of my subscribers were denied help from the state and of those who were allowed funding, it was only a small amount. We decided at that point that we would subsidize those low income subscribers with our fund rather than spending the time trying to acquire state funding.

If Medicare would pay for at least a portion of the monthly fee for my subscribers, it would be a solution to the problem. Many of our elderly are too proud to accept help from us, but need a system such as Lifeline so that if they need emergency help, they can get it. Lifeline has also allowed many elderly persons to remain in their own homes rather than having to be placed in a nursing home.

Medicare reimbursement for rural hospitals is another area of concern. We do not receive the same reimbursement as larger urban hospitals even though we are a regional medical center which serves a large rural population. This problem should be addressed by Congress to equalize payments to hospitals whether they are rural or urban.

I appreciate the opportunity to share my ideas with you and appreciate the fact that you are willing to look at possible alternatives for healthcare in rural areas.

Jane Parks

Jane Parks, Lifeline Specialist
Regional West Medical Center
4021 Avenue B
Scottsbluff, NE 69361

LETTER FROM STEVE BAISCH, M.D., FAAP, REGION WEST PEDIATRIC SERVICES, P.C.

June 1, 1990

Senator Bob Kerrey
Western Reginal Office
Scottsbluff, NE 69361

Senator:

Thank you for your interest in rural healthcare issues. For the record, I would like to submit the following comments and observations. There is a discrepancy in payment concerning where physicians practice. Physicians trained in the same schools and possessing the same skills are reimbursed differently from many different perspectives. The lay argument has been that different areas primarily urban vs. rural have different costs associated with them so they should carry respective levels of reimbursement. While I may choose to agree or disagree is irrelevant.

The underlying economic principle being ignored is that the "cost per patient" is greater due to population density, or the lack of density in rural areas. It does cost us as much to practice medicine in rural areas and sometimes more due to this fact. We encounter greater difficulty in getting medicine to people due to geography and when we do it is always on a smaller scale and the economics of size is lost.

Bascially the problem is fundamental. More costs are shifted to those people able to pay. With the growing cost of medical delivery and the incessant demand by patients for higher quality of care, coupled with increasing numbers of people unable to afford the care that is delivered, we have created an endless cycle of upward spiraling medical care costs.

Until the cycle is interrupted, no progress will be made. Everyone in my practice is looking forward to increased levels of compensation and higher standards of living. With the deficit as it is, inflation will continue to force us to keep pace and offer greater benefits and levels of compensation to maintain competency--so goes another vicious cycle of increased costs and higher fees. I do not know the answers but I understand the questions. I hope this information contributes to a solution. Thank you again for your concern and dedication.

Respectfully,

Steve Baisch, MD, FAAP

LETTER FROM ALBERT E. ROBINSON, PRESIDENT, ROBINSON & ASSOCIATES, INC.

Honorable J. Robert Kerrey, Senator of Nebraska
United States Senate
Washington, DC 20510

Dear Senator Kerrey:

I was planning to attend the hearing that you and Senator Daschle held in Scottsbluff, Nebraska today, however I was not able to do so. Therefore, please accept this letter as written testimony submitted relative to the above mentioned hearing.

I am an Allied Health Professional, Radiologic Technologist, who has practiced in the rural setting since 1961. In 1988, I "retired" from active practice to open my own company which specializes in healthcare professional recruitment and placement in the rural market place. Our firm, Robinson and Associates, Inc. is made up of Allied Health Professionals who live and work in the rural setting. We recruit M.D.'s, D.O.'s, R.N.'s, R.T's, M.T.'s, R.R.T's, etc. Our primary area of concentration is in the High Plains region from Mexico to Canada. Since we have spent our working life in this area and now have some experience with health care providers and professionals in this same area, we believe that we can provide a unique insight relative to the future of rural healthcare.

We believe that the manner in which healthcare is delivered in the rural setting must be completely changed if there is to be a future in the rural areas for any type of health care at all. We need to ask ourselves "why is all health care, obtained anywhere, dependent on the physician?" We are the only industrialized nation in the world that requires that every person use a physician as the only entry point to the medical profession. Part of the physician shortage could be addressed by allowing the public to access directly the services of the Allied Health Professionals and allowing some services to be conducted "without a physician's order". This would open access to services, allow greater and broader based delivery, and reduce the cost of such services. We would ask, as an example, why does a physician need to deliver every baby born in this country. Why not allow Midwives, Physician Assistants, or others who are qualified, work with the "normal, average delivery" thus allowing the physician enough time and energy to work with the difficult or high-risk deliveries. That's the way it is done the world over, why not here? We realize that medico-legal considerations cannot be ignored either. Another question one is forced to ask is "why must every X-Ray taken in a hospital be interpreted by a Radiologist?", when in many cases the interpretation is offered several days following the examination and treatment has either been initiated or completed at that point. This one item, required by law (Medicare) adds fifty to sixty percent to the cost of the X-Ray and in 98% of the cases does not contribute any additional information to the course of treatment. There are many more examples that could be sited in all of the allied health professions but in the interest of time and space, these two will serve as examples. Of course, these suggestions are not very popular with the physician community. This type of practice would reduce their income and thus reduce the cost of delivery of health care regardless of who is paying for it. Cost reduction should be the point of what we are trying to accomplish when we consider inclusion of "all the people" in any type of health care system.

Allied Health Professionals (nonphysician practitioners) have been confronted with the problems of retention, recruitment, and recognition for many years. We believe it is time to look at the fundamentals of these three concerns. We should ask ourselves "is a career in the allied health professions a job, a profession, or a career"? Webster's New Collegiate Dictionary defines job, profession, and career as follows: job "...for hire for a given service or period..."; profession "A calling requiring specialized knowledge and often long and intensive academic preparation.."; and career "... a profession for which one trains and which is undertaken as a permanent calling..." Until we redefine what allied health professionals do, we will be hard-pressed to recruit new people, retain our present talent and even harder pressed to achieve recognition from practitioners of other medical disciplines or the public in general.

The allied health professions are dominated by women today only slightly less that in the past. As recently as fifteen years ago a women coming out of high school had just about three choices as a career; teaching, healthcare, or homemaker. Today, of course, there is no career in which a woman cannot enter. Therefore, the "pool" of people available to enter the health professions has diminished considerably. Only recently have we seen men enter the allied health professions, for reasons we will discuss later.

Today's young people are entering college with many specific career goals already defined. They are looking for growth potential, appropriate and competitive compensation levels, and professional recognition. Prospective students in the allied health professions currently find that their growth potential is limited by their chosen discipline because of the fact, as discussed earlier, the physician controls medicine. There is no upward mobility in any of the allied health professions unless the professional leaves "direct patient care" and enters administration or teaching. Allow us to say it again in a different way, there is little or no room for growth, professionally or economically, if they remain in direct patient care, which is exactly what we are in need of. They soon discover that their compensation level is limited, in most cases, to a level 50% higher than their entry level, thus effectively, "capping" their earning potential. This "capping" effect is seen only in the allied health professions, not in business, teaching, or other professions. This again is related to the delivery criteria of medicine. Lastly, because of many misconceptions by other health care professionals and the public in general, most allied health professions are not given the recognition they deserve and therefore, leave the profession for another to achieve that recognition.

We would, therefore encourage you and your committee to review the delivery of medical care in this country compared to the delivery process in other industrialized countries in the world. Compare the access points. Can we afford to continue on this path from an economic basis or from a healthcare delivery basis? Where are the allied health professionals going to come from in the future if we cannot enhance their career opportunities both professionally and economically? Can we continue to give all of the money in the system to only physicians and hospitals? Are others in the system already qualified to perform some of the duties a physician currently is required to do? Can these things be delivered at a lesser cost by someone else and still maintain the quality of care? Is it appropriate to pay the rural health care provider 20-40% less than is paid to the urban provider?

It is apparent that we are asking more questions than we are answering. That is the point. We believe that all of the so-called "corrections" that the Federal Government has tried since its entry into medicine in 1965 have been basically "cut and paste" solutions. We believe that a reorganization of the medical care delivery system in this country must occur or the system, as it is organized today, will collapse of its own weight only after devouring a vast amount of our resources in the process.

We believe that the fundamental question in any system should be asked by the consumer: "How can I get only the medical care I need and want, at a price I can afford? Why am I required to pay for the services I do not need or want to support a system that has no end to its need for money? Why should I be required to pay for the hospital overhead, three physician consultations, and bad debt recovery to get an X-Ray of my ankle, which, as it turns out, isn't broken?"

You may think while reading this letter that it is certainly self-serving on our part to make these suggestions. Quite to the contrary. If the health care professional manpower crises were solved today, our company would close its doors tomorrow. It is in our best interest for everything to continue as it is, since the crisis will continue and our business, if we work hard, will survive and prosper.

Thank you very much for allowing us to contribute our thoughts in this manner. We look forward to the results of your hearings. We would offer our thoughts and services at any time in the future that we can make a contribution to your most difficult task.

Respectfully,

Albert E. (Al) Robinson, President
Robinson and Associates, Inc.

LETTER FROM JOHN J. RUFFING, JR., M.D.

Senator J. Robert Kerrey
United States Senate
West Nebraska Regional Office
2106 1st Avenue
Scottsbluff, Nebraska 69361

Dear Senator Kerrey:

I appreciate so much being asked to submit written testimony in regard to the Future of Rural Health Care. I wish that I could attend the meetings in person, but I will be in Lincoln at the time of the hearings.

I have written to both you and Senator Exon about the problems that have been created in my practice by continued governmental intervention. I have many patients in my practice that would like to pay the full cost of their medical care, but I am forced by governmental legislation to tell then that I cannot accept more than the Medicare allowance even when it does not even meet my basic costs.

The future for rural solo practitioners seems to me to be one of total extinction. I hear a lot from the media about what is being done to save "Snail Darters",and squirrels and other animals and birds from extinction, but I have yet to hear anyone in Washington taking note of the plight of the rural solo medical practitioner. That point right there should tell you where we stand on the political totem pole--so close the bottom that we are not noticed.

The things that I wish to present to the Committee are attached. If they seem to be rambling, it is because of the fact that for the past year, after working my 50 to 60 hour week in the office, I am forced to work a 60 hour shift at the hospital once of twice monthly just to help meet the costs of the office. This sad state of financial affairs is due to the fact that Medicare has frozen my fees, cut my laboratory fees by 50%, in some instances below my basic costs and is now considering other ways to save money by cutting my income without any reference to my costs.

The urban rural price differential is something that must be addressed and corrected.

Sincerely yours,

John J. Ruffing, Jr., M.D.

In regard to the Future of Rural Health Care in Nebraska, I submit the following written testimony and observations:

First let me give you a little background information so that you can see from what background I am speaking.

I was born in Crawford, Nebraska in 1934. I grew up on the family ranch in Sioux County that was homesteaded by my grandfather in 1886. As long as I can remember, I have wanted to become a medical doctor--that in part was inspired by Dr. Ben Franklin Richards, the physician who delivered me and who was our family physician while I was growing up.

My dream of becoming a physician was realized on June 5, 1960, when I received my Doctor of Medicine degree from Loma Linda University School of Medicine in California. After a one year rotation internship at Hinsdale, Illinois, I returned to Hemingford, Nebraska where I entered the private practice of medicine on August 1, 1961. I have been practicing at the Hemingford Clinic since that time.

As you may well be aware, there have been a great number of changes over the years. When I first started practice the cost of a day in the hospital was about ten dollars per day. Mal-practice insurance for my first year--just out of internship--was $72.00 per year and that included an office equipment rider and premises liability as well. My policy last year, after nearly thirty years of practice was nearly 100 times that amount, just for professional liability insurance.

Unless Congress and the individual states take some immediate steps to correct inequities in the reimbursement system, the rural solo medical practitioner will become extinct. Forced and regulated out of business by governmental regulation. I did not come to a rural area expecting to become rich. I came to a rural area with the expectation of having a good place to raise my family, a place where I could be of real service to the health needs of the community and a place where I could earn an income that would let me retire before the end of my life.

As it stands now, my family is all raised and away from home. I have been providing for the needs of the rural community with medical care, but in order to continue to keep my office open, I have to work at least one and sometimes 2-60 hour weekend shifts at the hospital Emergency Room just to help meet office expenses. This is after working my regular 50-60 hours in the office, and hospital and nursing homes. At this rate, I fear that I will face premature burn out. I have always been willing to work hard to acheive my goals. I was Valedictorian of my 8th and 12th grade classes and graduated from College with Distinction. In medical school I graduated somewhere near the middle of my class of about 100.

As I write this testimony, I am nearing the 50th hour of my 60 hour weekend on the hospital emergency room on the long Memorial Holiday Weekend. I am very tired, but I am assured that I can meet my office expenses for another month.

With continued governmental intervention to cut and slash and cut again the income of rural practitioners, the outlook for rural practitioners is grim. This coupled with what to me seems to be a totally un-realistic urban-rural payment differential. Case in point. I have a patient who was visiting in California recently and had to see a physician for a brief visit in a large metropolitan area in that state. The cost of his intermediate office call was $50.00. Medicare paid $40.00 and his medicare extended policy paid the other $10.00. The allowance for the same office visit here in Western Nebraska is something like $18.00. I beleive that I am correct in stating that my patient pays the same premium as the California Medicare recipient, but most of the times gets much less for his premium dollar.

Now, I can speak to the intensity of the problem with respect to Box Butte County than other areas of the state. When I came to Alliance and Hemingford nearly thirty years ago, we had eleven or twelve family practitioners on the staff of the Alliance Hospital. Today we have only five. One practitioner took an early retirement recently rather that be hasseled by medicare. I would also do the same thing at once if I could afford it, but I must practice for a few more years. In the last year we have lost our Orthopedic Surgeon, our General Surgeon and we are currently trying toreplace them as well as to attract more family practitioners to the area. However with the urban rural reimbursement differential it is nearly impossible to get a physician to consider a rural area unless you give high income guarantees and hospitals cannot afford to do that while they are loosing hundreds of thousands dollars per year due to Medicare DRG reimbursement not nearly meeting their costs.

Let me now give you some problems connected with my practice. This past year my office experienced approximately a twenty-five thousand dollar differential in income between what we are able to charge and collect from our private pay patients and what we are able to charge and collect from Medicare and Medicaide patients. There are now only 2 physicians left in Box Butte County that will accept Medicaide patients so this places a much greater load on us. This also places a greater income restriction on us since we must spend more time caring for more medicaide recipients for whom we are not completly reimbursed. Couple this with a continued medicare fee freeze, and the 50% cut in medicare lab reimbursement this places my practice at great financial strain and risk of closing.

If I were still educating my family, or making large house payments there would be no way that I could continue in the practice that I have built up over the past 30 years. As it is, I am not sure how much longer I can last working weekend shifts after a full week in the office.

So, as I see it from my vantage point, the future of rural health care is not bright. Unless something is done to get a more fair reimbursement and take into account costs and necessary profit margins rural solo practies will become extinct. Many more rural hospitals will close and the truly rural population will be medically uncared for. The big centers will get bigger and more specialized and the small towns will have nothing but first aid centers. Not a very pretty picture for the rural folks--but the people that make health care planning in Washington DC are not rural folks and they have no idea what problems face the rural people in terms of securing health care, and they most certainly have not the slightest idea of the economic needs of a rural practitioner.

I think that one of the most unfortunate parts of this whole mess is that I have lots of patients that would be most willing to pay the full cost of their medical care, but I am forced by governmental legislation to accept what you have determined to be the maximum amount without any regard to my overhead costs.

If there is any hope of saving the rural practitioner the health planners will have to get out of their ivory towers, out of Lincoln and Washington, DC and come to the Rural Area and see the problems they have created, then be willing to listen and take creative and necessary steps to re-vitalize and assure the survival of the rural health care delivery system.

Thank you for accepting my written testimony.

John J. Ruffing, Jr., M.D.

LETTER FROM LEE DIXON, CHAIRMAN, RURAL FAMILY ISSUES COALITION

May 30, 1990

Honorable J. Robert Kerrey
United States Senate
302 Hart Senate Office Building
Washington, D.C. 20510

Dear Senator Kerrey:

On behalf of the Rural Family Issues Coalition I want to thank you for the opportunity to testify concerning the mental health needs of rural Americans. Founded in 1986, the Coalition is composed of individuals who are concerned about the "human cost" of the changes that are affecting and will continue to affect rural America.

The 1980's were witness to a dramatic social and economic restructuring of rural America. At first, these changes were referred to as "the farm crisis" and then later the "rural crisis" but today there is general recognition that the term "crisis" is inappropriate. The changes taking place in rural America are neither short-term, temporary, or likely to return to the way things were. Rather, the changes in rural America, that so accelerated in the 1980's, represent a permanent and continuing reshaping of the reality of rural life. These changes have and will continue to have great human cost associated with them at a time when the resources available to persons living in rural America are decreasing at an accelerating rate. Rural Americans are rapidly becoming a disfranchised minority often lacking access to needed health and mental health and other human services.

Despite the increase in net farm income, many farm families still experience serious financial problems. The most recent USDA report on the financial conditions of U.S. farms (ERS, USDA, July 1989) indicates that 25 percent of the farmers with over $100,000 in cash sales have a debt to asset ratio of more than 40 percent. This compares to 28 percent of the farms with sales over $100,000 that had a debt to asset ratio of 40 percent or greater in 1985, at the height of the farm financial crisis. A disproportionate amount of the debt is found among larger farms, but 30 percent of the farms with a debt in excess of 40 percent.

Data from research studies, as well as records and experiences of professionals obtained in the past few years indicate that this financial pressure will lead to physical and mental health problems. If these mental health issues are not adequately addressed, the consequences will be the deterioration rural communities, the disintegration of many farms and rural families, and reduced individual well-being. A current example is Oklahoma where the farm suicide rate for the years 1985 - 89 has been 3.9 percent compared to 1.6 percent for the state as a whole. This dramatically high rate has prompted the Governor to appoint a task force on programs to reduce the rate. In addition, the 1988 report of the National Action Commission on the Mental Health of Rural Americans pointed out the serious lack of mental health counseling and outreach programs in rural areas and the toll it was taking as evidenced by increased incident rates of suicide, alcohol abuse, spouse abuse and depression. A copy of that report is enclosed for your review.

In response to these obvious needs the Rural Family Issues Coalition has developed two proposals which we believe can have a positive impact on rural Americans. They are:

1. Include in the 1990 Farm Bill the reauthorization of the counseling and outreach programs to aid farmers and rural families. Originally authorized as Section 1440 of the 1985 Farm Bill, this program can successfully bring together the services and capabilities of the Extension Service and state agencies for mental health, substance abuse and job training.

   Currently, both the House and Senate versions of the 1990 Farm Bill contain the reauthorization. It is our position that the funding for this program be increased to $15 million from its current $5 million so that more states and rural Americans can benefit from this program.

2. State offices of rural health and the federal Office of Rural Health Policy should have a specific and prominent focus on rural mental health. This focus would lead to an increased awareness of the problems and services that need to be addressed. In addition, it would lead to the integration of the health and mental health systems in serving rural America.

   To accomplish this the Congress should enact legislation establishing State Offices of Rural Health and instruct the Department of Health and Human Services to have its Office of Rural Health Policy give a higher priority to mental health. The Congress should consider establishing a demonstration program of health/mental health services linkage grants in rural areas as recommended by the National Action Commission on Mental Health of Rural Americans and the Office of Technology Assessment.

I have enclosed a briefing paper on each of these proposals that expands on the issues and the needs they address. We believe that these relatively simple and straight forward actions can make a difference and provide a much needed investment in the mental health and human resource needs of men, women and children of rural America. I would be pleased to provide you with additional information if you wish. I can be contacted at (202) 872-1445.

Sincerely,

Lee Dixon
Chairman
Rural Family Issues Coalition

FUNDING FOR MENTAL HEALTH SERVICES UNDER THE 1990 FARM BILL

Background

Despite the increase in net farm income, many farm families still experience serious financial problems. The most recent USDA report on the financial conditions of U.S. farms (ERS, USDA, July 1989) indicates that 25 percent of the farmers with over $100,000 in cash sales have a debt to asset ratio of more than 40 percent. This compares to 28 percent of the farms with sales over $100,000 that had a debt to asset ratio of 40 percent or greater in 1985, at the height of the farm financial crisis. A disproportionate amount of the debt is found among larger farms. Farms with sales of over $100,000 accounted for only 18 percent of the farms, but 30 percent of the farms with a debt in excess of 40 percent.

Data from research studies, as well as records and experiences of professional obtained in the past few years indicate that this financial pressure will lead to physical and mental health problems. If these mental health issues are not adequately addressed, the consequences will be the deterioration rural communities, the disintegration of many farm and rural families, and reduced individual well-being. A current example is Oklahoma where the farm suicide rate for the years 1985 - 89 has been 3.9 percent compared to 1.6 percent for the state as a whole. This dramaticaly high rate has prompted the governor to appoint a task force to focus on programs to reduce the rate. In addition, a 1987 study and continuing research by the University of Minnesota showed an increased rate of suicide and suicide attempts among adolescents in rural Minnesota.

The new families experiencing depression and other mental problems stemming from the dramatic changes in rural America and economic conditions in sectors of agriculture will be added to the backlog of rural individuals and families which have not received or had access to adequate mental health assistance in the past few years.

Issues

The immediate financial pressures for families with large debt loads and the social and psychological consequences of these pressures will not be altered by traditional commodity programs. The families' financial conditions are so desperate at this point that any assistance that might be coming through commodity programs in the next couple of years is likely to be too little too late. The question then becomes how can society best help these families - husband, wife and children - who will be caught in a financial crisis during the next few years?

Research studies and the experience of caregivers in rural areas during the past five years suggest that these farm families will have many unmet needs and will very likely suffer from a deterioration in the mental health of their members. Individuals experiencing depression tend to withdraw, lose confidence in their abilities, are at greater risk of abusing alcohol and/or drugs, behave in other anti-social ways, thus making it extremely difficult to meet the needs of their families or even re-enter the workforce as productive members of their community. This sequence of events and problems can put a further strain on already scarce community resources.

Section 1440 of the 1985 Farm Bill and the 1987 Rural Crisis Recovery Act recognized the multiple needs of families who were forced from farming and provided funding to meet some of these needs. This funding was used very effectively in some states to develop rural mental health outreach programs which were integrated into large caregiver or human service systems. However, in other states the funds were not used effectively, partly because the funds were used only for traditional Extension Service educational programs. Therefore, if the effort is to continue and have an impact on the services needed by persons in rural America it must have certain modifications that require direct service delivery as well as educational efforts.

Proposal

Include in the 1990 Farm Bill authorization and funding to support special service programs designed to help those families transitioning out of farming or experiencing other major changes that are occurring in rural America so they con continue to be contributing members of society; either in their community or elsewhere. Funding must be available to all states with a significantly impacted farm and rural population.

As a prerequisite to receiving federal assistance, states would be required to:

1. Develop an inter-agency effort with the relevant service agencies which focuses new state and local resources on meeting the needs of these families

2. Adopt an aggressive outreach component which addresses the mental health concerns of these families.

3. Have program efforts approved by the state mental health authority and effectively linked to the mental health system.

Impact

The adoption of such legislation would ease the human suffering and shorten the time span of the human cost experienced in the loss or threatened los of a farming operation or in other major changes in the lives of rural Americans. Although some studies have shown that most former farm men and women eventually become employed, most rural persons making dramatic occupational changes take jobs which require far less managerial and technical skills than they have. Most rural families experiencing such profound changes stay in their rural communities, but research indicates many do not continue as productive citizens of the community and many who do get jobs receive so little pay that they remain in poverty and draining resources from the community. Coordinated social service and educational programs built around mental health programs will improve the quality of life of rural families involved in the transition and enhance local rural development efforts.

Action Steps

Authorize and provide funding in the 1990 Farm Bill for human services, especially rural mental health services, which build on coordinated state and local efforts.

MENTAL HEALTH: AN INTEGRAL AND SIGNIFICANT PART OF RURAL HEALTH CARE

BACKGROUND

In the course of a year the mental health sector treats only 21 percent of all persons estimated to have emotional disorders. Fifty-four percent of the 32 million persons in the United States with a diagnosable mental disorder seek treatment exclusively in ambulatory general health care settings. This is likely to be greater in rural areas in part because of the scarcity of mental health providers.

A growing body of research establishes the connection between general health and mental health needs and care. On a clinical level, physical health and mental health do not separate easily into two distinct domains. Emotional distress often occur among patients in primary health care settings. Although the frequency of psychiatric disturbance in primary care settings is not known with certainty, evidence suggests that 30 to 60 percent of patients in general hospital units, end 50 to 80 percent of general practice outpatients suffer from emotional distress of sufficient severity to pose problems in medical management.

The interaction between psychosocial and physiological factors also appears in mental health practice. Careful physician and laboratory examination of psychiatric outpatient and inpatient populations have disclosed concurrent psychiatric and medical disorders in 30 to 50 percent of patients. Further, psychiatrically disturbed patients us about twice as many medical services as other patients; and since most studies indicate that psychotherapy reduces the subsequent utilization of medical care among patients with psychiatric disorders, untreated or improperly treated mental illness may be producing considerable drain on the resources of patients and the health care sector.

In summary, because of the strong correlation and co-occurrence of physical and mental disorder, better patient outcomes can be achieved from an approach that adequately addresses both the health and mental health domain. The recognition of the health-mental health interaction holds implications for organizational arrangements which encourage collaboration between the two systems. These organizational arrangements vary from simple information and referral procedures, to psychiatric liaison staff, to co-location of services. The linkage between health and mental health becomes all the more important when one realizes the magnitude of mental health needs in rural areas. The idyllic image of a problem-free countryside is belied by data documenting serious and widespread rural mental health problems. While some of these problems are directly related to the recent downturn in the agricultural economy, the data indicate that the prevalence of mental health problems has long-term endemic consequences for rural America; and that this prevalence has been and continues to be as great, if not greater, in rural as it is in urban areas.

ISSUE

Mental health needs and the resource capacity necessary to meet them are primary considerations when developing public policy and other initiatives regarding rural health care.

GOALS/PROPOSALS

One of the primary policy goals of the Rural Family Issues Coalition is to assure that new and existing rural health care initiatives specifically and prominently address mental health issues and that the resources be made available to meet the unique mental health care needs of rural Americans. The following are specific, short term proposals to achieve this end:

I. State offices of rural health and federal Office of Rural Health Policy shall have a separate, specific and prominent focus on rural mental health. This focus shall include assigned staff responsible for the are of mental health care, advisory board representation form mental health, and specific office initiatives directed at rural mental health concerns.

A. Expected Benefits: If state and federal level offices of rural health deal more directly with rural mental health issues as a distinct and important part of their general health care concerns, this should result in a heightened awareness of these issues and a greater interest in the integration of mental and general rural health care.

B. Action Steps:

1. Funds and legislative direction should be provided to the federal Office of Rural health Policy through the appropriations process to: (a) develop a policy-oriented report on rural mental health care; (b) fund a new rural research center with a mental health focus; (c) provide for mental health representation on the National Rural Health Advisory Board; and (d) support a staff position in rural mental health.

2. Legislation supporting the development of state level offices of rural health (such as that proposed by Rep. Stenholm in 1989) should include specific direction for those offices to address mental health care problems and issues.

II. A new demonstration program should be developed to enhance rural health care by providing resources for improving the linkage and/or integration of health and mental health services, including substance abuse. Eligibility for these grants would be limited to Community and Migrant Health Center Programs and Community Mental Health Centers. This program would be directed toward nonprofit hospitals and other health service providers in underserved rural areas. Funding should be through the Office of Rural Health Policy at $15 million annually.

A. Expected Benefits: This demonstration program would provide a catalyst to increase the availability of rural mental health services, better integrate physical and mental health and develop an understanding of the factors which make linkage and/or integration of mental and physical health services possible.

B. Action Steps: A new demonstration authority should be created within the Public Health Service or a line-item authority within an appropriations bill to establish this program.

III. The reauthorization of National Health Service Corp should specifically shortage of mental health professionals in rural areas by designating mental health professionals as a shortage category in rural areas and public health systems.

LETTER FROM DIANE E. GILLES, M.D.

May 30, 1990

Senator Robert Kerry
2106 First Avenue
Scottsbluff, NE 69361

Senator Tom Daschle

South Dakota

Dear Senators:

This letter is in regard to the problems of rural health management, especially in the area of the west when compared to those of the eastern United States. I grew up in North Dakota and have just recently moved back to what I consider to be the midwest area. I was in practice for approximately 4½ years in what is considered a rural area of southeastern Ohio, on the Ohio River and on the West Virginia border. This is obviously a depressed area of the country however as far as financial reimbursement goes, my financial reimbursement fees and schedules were much better than that that is allowed in western Nebraska. This is rather a disappointment and makes it extremely difficult to try to recruit people into this area and it will also be difficult to maintain a quality of health care in truly rural areas with this going on. My total hip fees in Ohio were greater by over $2,000.00 dollars for the exact same procedure and the maximal allowable charge that Medicare would reimburse was almost $1,000.00 higher. Such outrageous discrepancies within the system are totally unacceptable. The amount of my training has not changed any since I moved from Ohio to Nebraska and the amount of training in the physicians present in Nebraska is not significantly different. The malpractice rates between Ohio and Nebraska would not allow for the rationale that higher rates would allow such higher fees in Ohio when compared to Nebraska. Unfortunately with the more federal government involvement that has gotten into the health care system, the overlying layers of paperwork have not done much to decrease the costs and if anything have added burdens on layers of paperwork and expense to the system without really decreasing the cost or increasing savings.

I know that you gentleman are interested in solutions to the problems but there are such wide discrepancies within the system itself that it is hard to overcome the differences and come up with one easy solution. Unfortunately I think that the people in Washington tend to have data fed into them by people who tend to live in the more populous eastern part of the United States and that when you do move out west, that your voices are not heard as much. It seems very inconsistent that since our training is the same, that our services should be so much under valued. I came back to the midwest, obviously not because of the unfavorable pay scale but more because I miss the area that I grew up around. Unfortunately, because our popultation is so small, there are not many people who are going to continue to want to do this. As the reimbursement rates become less favorable, people will tend to stay more in the larger cities. There is a significant health care crisis but it is worse in truly rural areas than in the urban communities. I have enclosed for your information a sheet that gives you examples of some procedures that would be done in the Medicare population that shows marked discrepancies. Those two columns that are marked "Our Regular Fee" refer to the fees that are currently being charged by the group that I am with in Scottsbluff, Nebraska.

Thank you for your time and I do hope that you would look carefully at some of these figures to give you a better idea of some of the discrepancies that we are talking about.

Sincerely yours,

Diane E. Gilles, MD

Diane E. Gilles, M.D.

Surgery

		Ohio Fee	Ohio MAAC Fee	Our Reg Fee	Our MA
27130	Total Hip Replacement	$4,717.00	$3,167.00	$2,400.00	$2,188.
27447	Total Knee Replacement	4,717.00	2,532.00	$2,400.00	2,163.
29881	Arthroscopy/Menisectomy	1,870.00	1,396.00	1,250.00	656.
29870	Diagnostic Arthroscopy	1,135.00		609.50	326.
22612	Posterolateral Fusion	2,750.00	1,740.00	1,932.00	1,836.
25605	Closed Reduc Dist Radius	655.00	362.00	345.00	296.
28715	Triple Arthrodesis	2,094.00	1,325.00	1,240.00	1,236.
27590	Above Knee Amputation	2,094.00	1,325.00	1,104.00	949.
27880	Below Knee Amputation	1,838.00	1,160.00	966.00	835.
27870	Ankle Fusion	2,094.00	1,325.00	1,150.00	1,079.
27814	Bimalleolar Fx Ankle	1,311.00	830.00	862.50	780.4
28285	Hammertoe Operation, One	519.00	350.00	322.00	283.9
28290	Hallux Valgus (Simple (Exostectomy)	784.00	495.00	414.00	355.8
28292	Hallux Valgus (Bunion) Keller, McBride	1,055.00	700.00	552.00	544.2
28296	Hallux Valgus (Metatarsal Osteotcmy)	1,311.00	830.00	690.00	618.2
26418	Extensor Tendon Repair (Finger)	1,440.00	910.00	759.00	652.4
27236	Hip Fx - Prosthesis	2,365.00	1,543.00	1,495.00	1,285.
27244	Intertrochanteric Fx	2,365.00	1,421.00	1,357.00	1,166.5

STATEMENT OF PAMELA BARBOUR AND CONNIE LUNGRIN, SCOTTSBLUFF NURSING CENTER

There are many crisis situations facing rural health care today. Probably the most serious and far reaching problem is the shortage of health care professionals being attracted to the rural setting. Many factors influence their decision where to practice and only a few can be effectively changed by government involvement.

Greater incentives should be provided in the form of tuition assistance to those individuals willing to work in rural health care. More career and education and recruitment should be done geared toward the rural setting. Funding for this needs to occur at the college/university level.

Money services available in the metropolitian areas are not readily available in the rural area. Especially lacking in our area (Scottsbluff, Nebraska) are services for the mentally retarded/ mentally ill population. These individuals are frequently misdiagnosed and incorrectly treated. Psychological services are limited and no facilities exist to provide the specialized care these people need.

Another very real, rapidly increasing problem is the lack of facilities to provide care to the elderly mentally retarded developmentally disabled people. No facility exists in Western Nebraska to house these individuals. These people are not readily admitted to rural nursing homes because it costs more to provide care to these people than the state medicaid plan is set up to reimburse providers.

The problems with medicaid reimbursement in Nebraska already contribute to many of the problems in rural health care. The implementation of the OBRA regulations in October, 1990 will only compound an already ailing reimbursement system. Providers are not now being adequately reimbursed for the services they provide.

Using the national Consumer Price Index, 4½% and not the medical Consumer Price Index 8-9% in calculating reimbursement is a major contributor to this inequity. We are forced to frequently pay wages in rural health care, double what is paid in metro areas to attract and retain staff.

It is anticipated that implementation of the OBRA regulations will cost providers on additional 10-12%. OBRA regulations mandate this cost will be picked up by medicaid through the reimbursement system. I wonder how?

The OBRA regulation mandating 75 hour training for nurses aides with state competency testing has caused the work force we were once able to draw from to look elsewhere for jobs.

The desired effect of this regulation was to enhance the quality of care provided to our elderly. In fact all that has happened is we now have even fewer people willing to accept these demanding positions.

Staffing shortages are nation wide but especially hard hit is rural America. The OBRA regulation requiring RN coverage seven hours per day seven days per week will not be able to be met by at least 40% of the long term care facilities in Nebraska. There are not enough RNs to staff our long term care facility in the rural areas. Our rural recruitment programs usually are not a match for the large city campaigns.

Perhaps creation of specific training programs (college level) directed at rural health care needs would assist us in helping to get our needs met.

LETTER FROM C.N. SORENSEN, M.D.

3 June, 1990

Senate Finance and Appropriations Committee:

I commend Congress for enacting Obra "89. Among other benefits to Rural Health Care, this will eventually implament RBRVS, and hopefully put a final end to the flawed UCR system of determining Medicare benefits. However, the implamentation of this act is not scheduled to begin until 1992, and be completed in 1995. Rural health care in America, and especially in Nebraska, is in crisis and we need relief as soon as possible. Therefor I urge support of Rural Health Improvement Act sponsored by Senator Packwood, and designed to speed up implementation of RBRVS.

With the enactment of this legislation, the threat to the delivery of health care in rural America now comes from "Modifiers". Some have already appeared. Surely, finally, we in places like rural Nebraska are entitled to a fair deal. We should not forever be required to subsidize cities and other states where costs have not been contained. We plead that Medicare adhere to the principle of "equal premiums, equal benefits".

If you will give the providers of health care in rural America a "level playing field", they will be able to maintain and to upgrade rural health care. I don't think the cost will be significant. Perhaps, as more care is provided locally, there will be savings.

Medicare forms and processing of these forms must be simplified. As of now, each physician provider has an individual pay scale for each of the many provider numbers and many modifiers are applied. The result is long delay, many errors both by provider and by carrier, leading to frustration, anger, hostility and in general a very unhealthy relationship between provider and carrier. The trend is for all of this to get worse and worse. This trend must be reversed. The process must be made simple, efficient, honest and fair.

C N Sorensen

C. N. Sorensen, M.D.
4728 Cardinal Drive
Scottsbluff, Nebr. 69361
308-632-8035

LETTER FROM KATHY SCOTT, R.N., BSN.

June 3, 1990

Senator Tom Daschle

Senator Bob Kerrey

This letter is to convey my concerns relating to the future of rural health.

There are different payment systems for different parts of the country. It seems that reimbursement and other payment issues for both the hospitals and physicians are based upon the wage index of the area, but we still must compete for physicians and other health care personnel on a national basis. The hospital must still buy the same supplies as do other hospitals throughout the country but with less money because of different reimbursement formulas.

I see many people unable of buy insurance for health care coverage and then access both physician and hospital care without the ability to pay.

I am also concerned with the growing population of individuals who are elderly, and who have to choose between food or the medication that they need. Either option is not satisfactory for maintaining their optimum health status, so no matter what they chose, they will end up accessing the health care system sooner or later.

Thank you for your time and consideration.

Kathy Scott

Kathy Scott, RN, BSN.
Box 352
Mitchell, Nebraska 69357

LETTER FROM ELAINE SOVEREIGN

May 24, 1990

90 MAY 25 AM 10:18

Dear Senator Kerrey:

We appreciate your request for input for the upcoming hearings.

My husband and I wish to state that our position on health care, rural or urban, remains that we are strongly in favor of a national health insurance plan similar to the Canadian system. We feel that our present approach represents a band-aid solution while the quality of health care varies according to location.

One thing we feel is unfair is that fees charged and insurance claims paid are not standard for the same procedures, and therefore urban doctors receive more than their rural counterparts. Of course, this contributes to the shortage of rural physicians. Medicare schedules should be adjusted to more accurately reflect actual charges of doctors and hospitals. Although many elderly people do carry supplemental health insurance, as we expect to do when we reach that age, there are many who simply cannot afford to do so, and these costs must be borne by welfare programs when the individuals cannot pay. A national health plan would eliminate such problems and is, we feel, the ultimate answer to our country's growing health needs.

Thanks again for giving us the opportunity to express our views.

Sincerely,

Elaine Sovereign

Mrs. Cliff Sovereign

LETTER FROM ROBERT T. HARRISON, COUNTY SERVICE OFFICER

May 25, 1990

Senator Robert Kerrey
United States Senate
Washington, DC

RE: Rural Health Care in Nebraska
Written Testimony

Dear Senator Kerrey:

The condition of rural health care in Nebraska at this time is one of centralized metropolitan services with escalating costs beyond the average resident's income. In other words, you must travel a lot of miles to see a doctor that you can't afford!

Local facilities that provide health care to the people in the Panhandle have become nothing more than a referral center to larger hospitals. Some specialized services are provided by outreach programs from the larger hospitals, but travel to another city such as Scottsbluff, Rapid City, or Denver is still required to receive the necessary treatment for many of the patients.

These conditions are caused by our low population density and the skyrocketing costs in all facets of Medical Care. Hospitals are unable to provide high cost services where there is insufficient numbers of patients to make the venture profitable.

The inequitable Medicare Reimbursement between Urban and Rural hospitals only adds to the financial problems they face and make recruitment of doctors more difficult.

Through my position as Dawes County Veteran's Service Officer, the majority of my connections with health services is with the VA Medical Center at Hot Springs, South Dakota. This facility, under the present director, Mr. James Dudley, is one bright spot for the veterans in this area. Quality care is furnished to all veterans regardless of the income category the VA places them.

I am not ready to say a National Health Care Policy is necessary without a considerable amount of time spent looking into the costs and side effects. However, the plan such as the one in Canada seems to work efficiently.

There are a number of things Congress could do to relieve the problems on a short term basis, such as equalize Medicare Reimbursement, but I would hope your committees would look farther into the future.

The former Governor of Colorado, Dick Lamm, has expressed his view many times that there is a real problem when a nation such as ours would spend one hundred thousand dollars to keep one elderly patient alive for two additional weeks when that money could provide basic health services to a number of children.

The logic in this statement makes a great deal of sense when the availability of funds is limited, but it is a decision I would not be willing to make and I am sure Congress is not willing to allocate funds by age brackets.

The only answer to our diminishing Rural Health Care that I could see at this time would be for the people to let their elected representatives know of their priorities on governmental spending. Perhaps the time has come to take better care of ourselves and spend fewer dollars around the globe. The monies recently given to foreign countries by the present administration would have provided a substantial amount of health care for Americans that can't afford health insurance and are consequently denied access to such.

Sincerely,

Bob Harrison

Robert T. Harrison
County Service Officer
P.O. Box 1228
Chadron, NE 69337
PH. 308-432-5451
308-432-5487 (Home)

STATEMENT OF JEAN M. JENSEN, EXECUTIVE DIRECTOR, VOLUNTEERS OF AMERICA

I am submitting the following testimonial on behalf of the Volunteers of America regarding the future of rural health.

Jean Jensen

Volunteers of America, Lewellen operates "The Center for Health Promotion, A Rural Health Promotion Project." This project was selected for the Secretary's Award for Excellence as a distinguished community health promotion project by the Department of Health and Human Services in 1986. The project was organized by community volunteers and VOA staff to prevent death and disease caused by lifestyle. Programs address cholesterol, smoking, blood pressure, exercise, stress, nutrition, cancer prevention, safety restraints and alcohol and drug abuse in Garden County and the surrounding area.

The project has made a significant impact on our rural population during the six years since it began. Behavioral risk factor prevelency telephone surveys conducted in 1984 and 1989 show positive changes in health behaviors. Some of the changes are as follows:

-71% now make a conscious effort to reduce saturated fat in their diets
-10% more follow prescribed blood pressure treatment
-Regular exercise increased from 56% to 65%
-Monthly breast exams by women increased from 40% to 52%
-Smoking decreased from 27% to 21%
-Heavy drinking as defined by five or more drinks per occassion
declined from 17% to 9%

The VOA has received grants from the Federal Preventive Block Grants during the last five years. These funds have been very important in providing quality health promotion programs in our area. The funds have also provided opportunities for grants from non-government sources and connected our agency to state technical assistance. Federal funds have been more than matched with local support. Block grant funds account for $5000 out of a $40,000 annual budget this year. Local funds were used to build a health center and are the main income for operating costs.

Garden County is fortunate to have a private agency to coordinate health promotion programs as few Nebraska Counties have county health departments. County health departments do exist in higher population areas and one district health department exists which serves five rural counties. This limits health promotion/prevention services in Nebraska. The State of Nebraska ranks 48th in the nation in the amount of taxes provided for health and no funds are designated by the State for county health departments. Approximately 66% of the Nebraska Department of Health budget is from federal sources.

Nationally, money spent on prevention is important. Over 50% of all deaths in the United States can be attributed to lifestyle according to the U.S. Public Health Service. Millions of dollars are spent on treating heart disease, stroke, cancer, accidents and drug abuse. Dollars spent on prevention are cost effective, avoiding expensive treatments while increasing the quality of life.

Health promotion programs have made a difference in Garden County with the financial and technical assistance provided by the Nebraska Department of Health. Unfortunately, many rural communities do not have these services or the structure to put them into place.

As a member of the Lewellen community I would like to share the concerns for health that I hear. The primary concern of most residents is the shortage of family practitioners in our area, followed by concern for the financial instability of our local hositals. Many people would like to live in our area but do not because of 1) limited economic opportunities and 2) limited medical care. For example, insurance rates have driven many doctors out of obstetric care leaving women in our county driving from 35 to over 100 miles for prenatal care and deliveries. For poorer families especially, this puts an additional restraint on good prenatal care.

According to local physicians and hospital administrators the main problem in recruiting new family practitioners and in keeping hospitals open is the unfair schedule of medicare payments to medical providers in our area. I understand that rural Nebraska receives approximately half that of Lincoln or Omaha and that Nebraska is one of the lowest paid states for medicare. This, in spite of the fact that Nebraska residents pay into medicare at the same rate as the rest of the country. Many doctors want to live in rural Nebraska but find they cannot afford to live here. One surgeon stated in a rural health forum that he received five times more for the same procedures in Detroit when he began his practice than he does now serving western Nebraska.

I suggest the following governmental changes:

-Medicare payments should be standardized regardless of geographic location.

-Payments to family practitioners should be increased while decreasing specialized procedures to encourage more people to specialize in family medicine.

-Priorities need to be established for payment on medical procedures. The country cannot afford to provide every possible medical procedure for every citizen.

-Financial assistance for physicians, nurse practitioners and nurses should depend on the individual serving in designated areas experiencing shortages in medical care for a number of years.

STATEMENT OF JOELLEN VRBKA, ADMINISTRATOR, BUTLER COUNTY HOSPITAL

My name is JoEllen Vrbka. I am administrator of Butler County Hospital in David City, Nebraska which is about 70 miles west of Omaha. I'd like to divide my presentation into three parts: addressing the increasing health care costs; impact of PPS on rural hospitals and what we have done in David City to cope with all the changes.

I would first like to share a few of my thoughts regarding the crisis in health care.

I believe that there need to be incentives in place that encourage healthier lifestyles. It doesn't seem fair that non-smokers, people who exercise, maintain a reasonable weight, wear seat belts, and have annual preventative check-ups pay the same health insurance premium as the person who pays very little attention to his/her health. Some employers are moving in that direction and perhaps more thought should be given to such an approach.

There are too many people without health care. My grandson had open heart surgery through a program for children born with heart defects because our children had no health insurance coverage. I see the problems associated with no insurance and resulting lack of preventative care. I also see unlimited patient expectations. If we get sick, we expect to go to Mayo's for care if desired. Care is limited by third party payors through admission review and pre-certification for inpatient care. However an illness can be treated almost anywhere regardless of the cost of that care. Patients who have been confined to a nursing home and in bed for some time still can have pacemakers. Now, Medicare will pay for heart transplants. If we have health insurance, we have pretty much unlimited acess to technology. I'm not saying that this isn't right. I am saying that we cannot have the cadillac for some people and expect to pay the price for a "Honda" and then provide other people with a bicycle or expect them to walk.

My father had a heart attack in the early seventies and his bill was a fraction of what it is today. In those days, they couldn't do much for him except monitor his heart and give him medicine. He had heart damage and lived three years after that. My 43 year old brother had a heart attack last summer. He received the new drug called TPA which dissolves clots and costs about $3500. He needed the balloon angioplasty to open up some of the arteries around his heart to relieve severe pain and that was done within 5 hours of his heart attack.

His bill for that first day was over twelve thousand dollars. When the quality of life is considered the money was well spent, as he had little damage. High tech is becoming the standard of care for heart attacks and impacts national statistics leading us to believe the cost of health care is out of control.

Society at large faces a problem of deciding what is appropriate. If we want unlimited access to technology, we must be prepared to pay for that care. There are going to be very difficult personal and ethical choices to be made if we are to control the cost of health care. We may have to decide on some kind of basic health care for all and limit access to the high-technology kinds of care to those who would benefit the most from that care.

We are also going to have to face the liability crisis. There are an awful lot of tests being ordered in the name of defensive medicine. Some common sense must be applied. True negligence deserves it's day in court. However, some way needs to be found to decide what is true negligence.

We also need to look at cost-benefits of treatment. If I ever have a stroke at the age of 80, please don't put me on a respirator and spend thousands of dollars on me only to let me live in a nursing home for several years and bankrupt my family.

I just cannot believe the only answer to controlling health care is to reduce the payments to providors. We're struggling to provide "quality care", and provide for the health care needs for our community. We need to continue improving efficiency and effectiveness of our care.

Now back to the real world. This is where rural hospitals are now.

The advent of payment by diagnosis in 1982, as you know, has produced drastic change for hospitals. Rural hospitals, in particular, have been working at a disadvantage because they received as much as 40% less than urban hospitals for similar diagnosis. During the last 2 years, Congress has approved larger increases in Medicare reimbursement for rural hospitals and the gap has been narrowed. Presently, rural hospitals in Nebraska receive 26% less than Lincoln hospitals and 29% less than Omaha hospitals for similar cases. There still are significant differences in the wage index which is used as a factor in calculating payments to hospital. In October, rural hospitals will receive a proposed 2% decrease, Omaha .9% decrease and Lincoln 1.5% increase in Medicare payments. Our update is higher but is wiped out by the decreased wage index. The DRG classification is also being revised resulting in 0.9% decrease to rural hospitals in addition to the 2%.

The difference in payment rates for rural and urban physicians also affects hospitals. Doctors remain at the center of health care delivery for obvious reasons. A Nebraska hospital administrator told me last week that he was losing one of two physicians in his community because that physician could make $35,000 more per year in an urban practice doing much the same thing with regular hours and other quality of life benefits.

Rural hospitals in Nebraska have a higher percentage of Medicare patients than urban hospitals. Prior to PPS, we were paid our costs for treating Medicare patient. Last year, 66% of the inpatients at our hospital were Medicare patients and we would have received 66% of our inpatient costs to take care of them. Now, we receive a set amount for each Medicare patient without regard to our cost. Rural hospitals, because of minimum levels of staffing,have difficulty in achieving costs within payment rates without sacrificing quality. Congress is allowing us to choose the cost-based payment based on a utilization of Medicare patients in the 1987 fiscal year which might not reflect the Medicare percentage this year because of the rapid change going on.

When PPS was implemented, a Peer Review Organization (PRO) was put in place to make sure that care was appropriate, in the proper setting and of high quality. Insurance companies and other third party payors followed suit and began monitoring care. This has led to increased outpatient services because some of the care being provided could be done as an outpatient. Increasingly, even complex procedures are being done as outpatient procedures. Now, we hear that outpatient cost of care is too high and must be controlled. Medicare has reduced some of our outpatient reimbursement which further exacerbates the problem for rural hospitals. Logically, it seems to me that we would expect higher costs if there were more outpatients. Cost per visit has to go up if we are doing more complex things. We need to look at the whole system and measure the utilization of personnel and technology before just reducing outpatient reimbursement across the board.

I notice that monitoring the quality of care and making sure that care is appropriate are high on everybody's list of ways to control costs. I believe that system is already in place. We don't need any more data, paper work or monitoring systems. Let's fine-tune the system we have, if necessary to accomplish goals. We all know that statistics are easily distorted when only small numbers of cases are used. We've learned to deal with mortality figures where one death in a small number of cases gives a higher than average percentage of deaths. Another system to measure quality will not be cost effective for us.

Another problem faced by rural hospitals is the shortage of health professionals. We don't have the flexibility of shifting people around depending upon what area of the hospital is busy. We have to have a minimum number of staff available in order to provide emergency care. At our hospital, we never have less than two registered nurses and two nurse aides on duty in order to be able to respond to emergency situations. The shortage of health care professionals has forced salaries which are competitive with urban hospitals in order to attract and retain employees. Many rural hospitals can't get nurses, therapists and other staff at any salary. We need to address the problems of these shortages. In Nebraska, the Associate Degree program for nurses and programs for other health care occupations have been instituted in community colleges. This may help rural hospitals as many of these colleges are within driving distance for people likely to remain in rural areas.

We also face licensure, quality and regulation problems that are financially very difficult to respond to. For instance, our insurance company recommended a documented preventative maintenance program to protect us from a lawsuit due to defective equipment. Our Workman's Compensation premium doubled for next year. Health insurance premiums are increasing for our employees. I expect our property and liability insurance to increase. We've had to add a half-time registered nurse to screen all discharges for quality and to improve utilization review for all inpatients. These few items will more than wipe out the 1% profit margin we have after 10 months of this fiscal year. Employees will expect a cost-of-living adjustment next January. Add this to the decreased payment from Medicare due in October and we'll be faced with some hard choices in order to make ends meet in our operating fund. We can try reducing staffing through productivity, use invest ment income to operate in lieu of planning for the future, increase the services we provide or shift costs to the NON-Medicare patient by increasing prices.

Quality is hard to define. By and large, I think rural Nebraska hospitals do the best possible job within the limits of their resources. We try to do the things we can do and we refer those that we can't do. People who are in our hospitals define quality as "a caring hospital", people know who you are and care about you. They answer your bell promptly, give you good food and take care of your illness. Some studies suggest that the size of the hospital does not affect the outcome if the scope of services is linked to the size of the hospital. We don't do "total hips" for instance, because that would require greater expertise than we have. We, however, do fix broken hips in our hospital and do a good job of it.

Our patients get well and Medicare gets a bargain because they pay less to have that hip fixed in our hospital than in an urban hospital.

If we weren't there or if we couldn't fix that hip, the cost of travel and accessability of care are two factors that must be considered.

In Nebraska, there are 79 rural, general acute care hospitals and 10 urban hospitals. During the last 10 years, there have been 7 hospitals who closed their doors. The economic loss to those communities has been substantial. There are several Nebraska hospitals who are at risk of closing. Also, rural hospitals for the United States as a whole, have older facilities and many may need to be replaced in the future.

In David City as in other hospitals, we've done a lot of things to cope with the changes in Health Care. We've tried to improve the productivity of our staff. We've instituted cross-training where possible. Our X-ray tech, for instance, is also our purchasing agent. We've teamed up with Schuyler hospital which is about 18 miles away for our anesthesia services. Our 2 hospitals jointly employ two anesthetists who provide relief and time off for each other. We're also working with two other hospitals to jointly purchase equipment for a surgeon who will see patients and come to all our three hospitals.

Early on, we knew we needed to plan where we were going and we spent some time and money to do that. Out of that, we have entered into some joint ventures with our physicians to establish a satellite clinic which has helped increase our service area and stabilized the trend towards reduced inpatients. We have added a Wellness Center and enlarged Physical Therapy which was made possible through the generous donations and support of our community. This Wellness Center lets us put an emphasis on preventative medicine. We have added cardiac rehabilitation. Another physical therapist has been added to our staff and another physician was added three years ago at the Butler County Clinic. This Doctor told me a hospital with good facilities and the physical therapy and wellness center addition influenced his decision to come to David City.

A physician's assistant will start working in July to help with their workload at the Clinic and also staff another satellite clinic to be opened this fall.

Butler County Clinic has had good luck recruiting and retaining physicians. One of the reasons is their group practice situation. The Doctors have adequate time off. We're also located only an hours drive from Omaha or Lincoln which helps immensely. Consulting specialists and mobile services come as needed. We also work at getting physican input on decisions affecting them and we provide the equipment and level of expertise needed in professional support for their practice. We work hard at communication with the Medical Staff, hospital staff and community. If we don't work as a team, we are doomed to failure.

There may need to be more working together by communities to provide the level of health care needed for their community. Perhaps hospital that are located close geographically can band together for emergency weekend coverage. Maybe, people will have to go X hospital or Y hospitals on alternating weekends for ER care. Right now, I doubt if regulations would allow that and change may be needed. Such an arrangement might help doctors get weekends off and make a rural practice look more attractive. Hospitals must be ready to offer help to physicians when asked. Working together, we can solve some of the paperwork problems expecially in coding and Medicare claims.

I know that there are a number of sharing arrangements already in place in Nebraska hospital. Our Physical Therapists also staff 2 other hospital's P.T. departments. I know of rural hospitals that share administrators, anesthetists, respiratory therapists, physical therapists, inservice education, etc. Nebraska hospitals, by and large, have worked at being as productive and efficient as possible.

I'd like to thank you for the opportunity to testify on behalf of rural health care and I look forward to helping in anyway that I can to improve accessibility, quality and cost of health care in the future.

STATEMENT OF ROBERT H. WALDMAN, M.D., DEAN, UNIVERSITY OF NEBRASKA COLLEGE OF MEDICINE

Senator J. Robert Kerrey and Senator Thomas Daschle:

Thank you for your invitation to join this discussion of rural health care problems. The topic is of highest importance to me personally and to the mission of the University of Nebraska Medical Center. We believe one of the major problems facing medicine in Nebraska and the nation is the maldistribution of our physicians--both by specialty and by geographic distribution. There are simply too many specialists and not enough primary care physicians; there are too many physicians in large cities and too few in rural areas. Many complex factors contribute to the physician maldistribution problem; some are beyond the control of academic medical centers. Others, however, can be effectively addressed through innovative programs. I feel positively about our ability to influence the maldistribution problems through careful recruiting strategies, coordination and integration of the education continuum from high school through residency, and good role models in primary care and early experiences in rural practice sites.

One solution to providing more physicians for underserved areas is to identify and recruit promising students from those underserved areas. We know that students recruited from rural areas are twice as likely to return to these areas after finishing their education. Rural, disadvantaged, and minority students need to be informed that a career as a health care professional is a viable option. There are many myths and misconceptions about what is required to get into medical school. Students may think they must have straight A's, be rich, know influential people, or be chemistry majors to qualify. We can begin to correct these misconceptions starting with students at the middle school or junior high level. We should take a page from college athletics and do real recruiting of promising 7th, 8th, & 9th graders. The high cost of medical education and the lengthy educational preparation required can also discourage rural students from considering medical school. These barriers can be reduced thereby attracting capable students who might have ruled out medicine because they thought they could never afford it.

Medical education is very long, in part, because of lack of integration in the educational continuum. Traditionally, students prepare for health care careers in separate, disconnected institutions. High schools, colleges, medical schools, and residency programs lack coordination and the result is a disjointed educational experience with waste and duplication of courses as each school strives to give students comprehensive preparation. When education on all levels is coordinated, waste will be eliminated and the curriculum will be enriched. A coordinated educational continuum can cut two years from the traditional medical preparation without any loss of educational material, thus saving money and appealing to disadvantaged students.

Another problem with respect to attracting students to a career in rural primary care relates to the research mission of the academic medical center. Because of advances in medical care and technology, medical centers have become increasingly high tech institutions. It's becoming more difficult to provide the diverse experiences required for rural health care education within the walls of academic teaching hospitals and existing teaching sites. Researchers and clinicians are highly specialized, often choosing to focus on one small aspect of a disease or problem. Moreover, the highly specialized services that university hospitals have developed attract patients with uncommon problems or patients in need of highly specialized procedures. Thus students see patients who are much sicker and have very different problems from those seen by a typical primary care physician. The high tech, research intensive, specialized care is naturally very seductive with respect to career decision-making.

Students should spend more time in rural areas early in their education to balance the highly specialized, tertiary care they encounter at academic medical centers. They need to know they can practice exciting high quality medicine away from research centers. Primary care role models who can share the benefits of good patient/physician interaction and personalized compassionate care are important. They can show students that a career in primary care can be a satisfying and exciting one.

Having briefly defined some of the ways our current medical education system contributes to the rural health care manpower problem, I would like to describe some potential solutions we have created at UNMC. When a decline in rural applicants to the Med Center was noted, we initiated a cooperative program with Chadron State College--the Rural Health Opportunities Program. This program recruits students from small rural communities to become physicians, physician assistants, medical technologists, and dentists. Students enroll at Chadron State College where undergraduate studies are coordinated with UNMC; they are automatically accepted into our programs upon satisfactory completion of undergraduate work. Students in the M.D. program begin studies at the Med Center during what would ordinarily be their senior undergraduate year, thus reducing the total educational time by one year. Our first class of eleven students will start at Chadron State this Fall. Several of these students would not have considered medicine as a career without this program.

UNMC is currently exploring the possibility of a rural educational site. We feel it would have multiple advantages, providing broad exposure to health problems typically seen in primary care settings, providing interaction between students and rural health professionals, stimulating early student interest in rural health care, and introducing students to health problems common in underserved and rural areas of the state. We are also exploring the option of a family practice residency program in a rural site. Since residents tend to settle in areas close to those where they train, it follows that training should take place as close to where doctors are needed as possible.

Finally, the University of Nebraska College of Medicine, along with a few other medical schools, has developed a curriculum which will enable students to start primary care residencies in their senior year of medical school, freeing them from the time-consuming and expensive task of interviewing for residency positions around the country. The program has the added advantage of encouraging graduates interested in internal medicine, family practice, and pediatrics to remain in the state for their residencies.

It would be naive to suggest that the programs described here will solve the entire maldistribution problem; other important factors must also be addressed. Medical schools can and should do everything within their power to find creative solutions to this pervasive problem. We hope the changes we are making will have a positive impact on this country's physician maldistribution problems, and will at the same time, produce physicians who are better prepared to practice medicine in the 21st century.

STATEMENT OF TERRY REICHERT, WESTERN NEBRASKA LEGAL SERVICES

Introduction

As an advocate of Western Nebraska Legal Services we face health issues on a daily basis. We appreciate this opportunity to provide, you, Mr. Senators, with an overview of existing problems which are prevalent in our society today.

The issues at hand which we would like to focus on are access to healthcare services, rising healthcare costs, and long-term care. Within each issue we have various topics we would like to cover.

As far as access to healthcare services, given our potential client population base of Western Nebraska Legal Services we find that our client population base along with similiar population bases, suffer from inadequate healthcare for many reasons; lack of education, lack of access to hospitals, lack of doctors in rural areas and access to those doctors, poor nutrition, and poor living conditions, etc. It has been reported that there are 31-37 million U.S. citizens who are uninsured not taking into account the persons who are underinsured in our society. At the present time the people who are most likely to purchase insurance at a feasible level are the "sickly" type person because of the nature of their conditions, if they have the ability to pay for this coverage, whereas the healthier individual will most likely not pursue the purchasing of health insurance just because they are healthier. This creates an increase in medical coverage thus esculating healthcare costs because a typical health consumer does not absorb the cost. Along with this there is an ever-increasing medical insurance cost within the medical industry itself. This creates a rebound effect and increases medical expenses. This relentless increase of medical prices, coupled by cut-backs in government programs and cut-backs in employer-sponsored health insurance coverage also contribute to the cycle of the uninsured and the underinsured persons.

For more than a decade, increasing healthcare costs have increased the awareness of policymakers on the healthcare system and resulted in several schemes to control healthcare spending but to no success. At the present time the healthcare industry is one of the largest and fastest growing sectors of the American economy. Americans spent over 11% of the gross national product in 1987 for healthcare. It is predicted that healthcare expenditures will be over 15% of the GNP by the year 2000. As you can see, healthcare is an ever-increasing battle whereby legislation in itself isn't a cure-all.

Within the legislative bodies for medicare and the social security administration procedural process we find many inefficiencies and duplication of administrative processes whereby there are no benefits provided to the claimants themselves. The Social Security Administration procedural process is governed by the Code of Federal Regulations #20. Within the administrative process a typical claimant who signs up for disability is most likely denied Social Security Disability benefits because it is a standard practice of the administration to deny a claimant based on its intake information in order to deter and hender so-called "malingerers". By doing this the administration places a burden on the claimant physically, mentally, and financially. The appeal process is described as follows. A claimant files an initial application, after he/she is denied he/she must appeal within 60 days and then he/she is usually rendered the same decision at reconsideration. Then he/she is given an additional 60 days to file an appeal to the administrative level whereby he is given a face to face contact with a Judge at an administrative hearing. At this level, WNLS has been highly successful in their representation with the claimant.

Out of the 120 people which I represented personally, only one person was denied at the administrative hearing level. This shows that it is apparent that the Social Security Administration is not making an accurate decision at the initial application. In the meantime, the claimant has to suffer without a steady source of income for a 2-3 year period prior to the hearing stage for Social Security Disability and must seek alternate forms of financing in order to sustain their existence.

Other options which are available are state administered programs such as the Nebraska Department of Social Services who may provide Medicaid and Aid to Dependant Families with Children-Incapacitated (AFDC-I) if in fact a person has children and a person has worked in the past prior to the illness. If they have not then they will fall between the inadequacies of the social systems.

Another alternative may be the state-aid program which is called AABD also known as Aid to the Aged, Blind, and Disabled. However, this program requires that you be found disabled by the Social Security Administration prior to acceptance. It is very apparent that there are great numbers of people who fall between the cracks of the social healthcare programs. We believe that it would be in the best interests of the United States Legislatures to enact such legislation as would enhance the coordination and implementation of the state and federal laws to provide more direct health services to the uninsured and underinsured. Efforts must be made to provide citizens with health services rather than the present bureaucratic "red tape."

Also along with the immediate medical attention needs of individuals, a long-term healthcare program should be implemented and enacted by the federal government. At the present time one of the greatest deficiencies in health and the social service systems is a lack of comprehensive, and coordinated long-term care services. Long-term care is described as a range of medical, personal, and social services developed to coordinate the physical, social, and emotional needs of the chronically ill and disabled persons.

It is our position that a new reform for our health care system including immediate, short-term and long-term healthcare should start with legislation and should be coordinated with the social systems at all levels to maximize efficiency for individual citizens in providing appropriate healthcare.

STATEMENT OF RAE ANN SCHMITZ, WESTERN NEBRASKA LEGAL SERVICES

Income disparities have widened in recent years both between the rich and the poor and between wealthy and middle-income Americans. The most wealthy Americans reside in urban areas and rural areas account for a disproportionately large share of people with low incomes. These widening income disparities have been accompanied by a grbwing rural urban income gap. Tax policy changes now under consideration that primarily would benefit upper-income Americans would likely widen these gaps even further.

In 1988 the richest fifth or 20 percent of all families in the United States received 44 percent of the national family income; the middle fifth of families received 16.7 percent of the national family income, a record low; and the poorest fifth of families received 4.6 of the national family income, tying for the lowest share since 1954. Between 1979 and 1988 the average income of the richest fifth of families increased by 12 percent; the average income of the wealthest five percent of families rose 16 percent. By contrast, the average income of the poorest fifth of families fell six percent; and the average income of families in the middle fifth rose one percent. This census data reflects pre-tax income. It does not reflect the impact of proposed changes in the Federal Tax Code.

A recent analysis by the Congressional Budget Office found that between 1980 and 1990, the poorest fifth of American families will experience an average after-tax income loss of three percent; the middle fifth will experience an average increase of eight percent; the top fifth of families will realize an average increase of 32 percent; the richest five percent will secure an average after-tax gain of 46 percent; and the top one percent of families will obtain an average increase of 75 percent.

In other words, the wealthest one percent of the population will receive nearly as much after-tax income as will the poorest 40 percent of tax payers put together.

This growing gap between wealthy and other Americans has somewhat different implications for rural and urban areas.

In 1987 census data shows as follows:

National Income Catagory	Rural	Urban
Richest Fifth	11%	23%
Next Richest Fifth	17%	21%
Middle Fifth	21%	19%
Next Poorest Fifth	25%	19%
Poorest Fifth	26%	18%
TOTAL	100%	100%

Looked at another way, few wealthy people live in rural areas. 88 percent of the richest fifth of households reside in urban areas. 29 percent of households in the poorest fifth live in rural areas.

The link between these two trends - the growing gaps between wealthy and other Americans and growing income disparities between rural and urban areas - has implications for public policy. For example, the Medicare reimbursement policy which reimburses urban hospitals at a higher rate than rural hospitals tends to further widen the gap between rural Americans and their urban counterparts. In other words, such a public policy results in a transfer of income and resources from rural to urban areas which further widen the rural-urban income disparities.

A modest portion of the gap between rural and urban incomes may be offset by differences in the cost of living in these areas. Housing costs, for example, tend to be higher in urban areas, but other cost items such as transportation, tend to be more expensive in rural areas.

No study has conclusively quantified rural-urban cost differences across the whole range of family budget items, in part because the necessary data are unavailable. It is unlikely that any adjustment for cost of living variations would have much effect on the finding that a highly disproportionate share of the wealthiest Americans reside in urban areas.

In 1979, the average rural jobs produced earnings of $19,945.00 as compared to $24,908.00 in earnings produced by the average urban job. By 1987 the average rural job produced earnings of $18,270.00 and the average urban job produced earnings of $24,455.00. As a result, by 1987, the average earnings from a job in a rural area were 25 percent less than the average earnings from an urban job.

In 1979 32 percent of rural workers earned a wage too low to lift a family of four out of poverty with full-time, year-round work. By 1987, some 42 percent of rural workers earned wages too low to lift such a family out of poverty. In 1987, only 29 percent of urban workers earned wages too low to lift a four-person family out of poverty.

What this means is that urban dwellers who tend to be richer receive more public benefits via medicare reimbursement policies at the expense of rural dwellers who already tend to be poor and have less access to healthcare services. Another implication of these figures are that 72 percent of rural families fall in the middle fifth or next poorest fifth or poorest fifth of the national income categories. It would make sense to extend medicaid health insurance coverage to those working poor households which fall in those categories, thus closing the gap between urban-rural disparities.

One of the most striking characteristics of rural poverty is the extent to which the rural poor work. Nearly two of every three poor families living in rural areas include at least one worker, and nearly one in four such families have two or more workers.

While more than half (54.1%) of poor urban families had at least one person who worked in 1987, some 64 percent of poor rural families did. Additionally, many of the rural poor families that did not have any workers are families in which the adults are elderly or disabled.

While most nonworking poor families with children have medicaid coverage, most of the working poor are ineligible for medicaid. Many of the working poor also do not receive health insurance coverage through their jobs. As a result, in 1986, nearly half (48%) of poor children living in households in which they had worked full-time, year-round were not covered by any private or public health insurance. Only 18.2 percent of poor children living in a household in which the household head worked full-time had medicaid coverage. Extending medicaid coverage to more poor children would have an expecially large effect in rural areas. Most of the poor children without health insurance coverage are children who live in working families and working poor families are disproportionately located in rural areas. Moreover, some of the most rural states have especially restrictive medicaid eligibility rules, which deny eligibility to many working poor families.

Consider these statistics: in 1986, 48 percent of poor children living in households in which the head worked full-time, year-round were not covered by any private or public health insurance. By comparison, 69 percent of the poor children in non-working households had public or private health insurance.

Efforts to extend medicaid coverage to poor children who do not receive AFDC primarily benefit children in working families. Such efforts should have an especially large effect in rural areas.

Of the state medicaid options, one that is particularly significant for the working poor is the option to adopt a "Medically-Needy" program. The Medically-Needy option allows states to set medicaid income eligibility limits up to one-third higher than the state's maximum benefit level for AFDC. If a state uses this option to raise its medicaid income limits above the AFDC benefit level, more poor families with children become eligible for medicaid coverage.

Moreover, if a state adopts a Medically-Needy program, a family whose "countable" income exceeds the states medicaid eligibility limits, but whose medical expenses are so large that its remaining income after some medical expenses are deducted are below the eligibility limits, becomes eligible for medicaid coverage for its remaining costs.

The Medically-Needy option thus allows states to extend medicaid to a significant number of poor adults and children age 6 and over who live in families that do not receive AFDC. Most of the families who are covered under this option are working families.

Some 36 of the 50 states do have Medically-Needy programs. However, the states that do not provide this coverage are disproportionately rural states. Of the 14 states that do not have a Medically-Needy program, half are among the 15 most rural states in the nation. In addition, in many of the rural states that do operate a Medically-Needy program, the income eligibility limit for medicaid is set quite low.

If more states were to adopt a Medically-Needy program or to raise their medicaid income eligibility limits, coverage would be extended to more children in working poor families that lack health insurance.

There is also a possible federal policy initiative that could, over time, bridge the health insurance gap for children from working poor families. This is a proposal to require the states to extend medicaid coverage by the year 2001 to all children under age 18 living in families with incomes below the poverty line. The principal effect of this legislation would be to extend coverage to poor children in working poor families that lack health insurance.

SOURCES

Fulfilling Work's Promise; Policies to Increase Incomes of the Rural Working Poor, Isaac Shapiro and Robert Greenstein, Center on Budget and Policy Priorities, Washington, D.C., February 1990.

The Rural Disadvantage, Growing Income Disparities Between Rural and Urban Areas, Scott Barancik, Center on Budget and Policy Priorities, Washington, D.C., April 1990.

LETTER FROM SHARON WITT, R.N., DIRECTOR OF NURSES, GORDON MEMORIAL HOSPITAL

Senator Bob Kerry
194 Dirksen
Washington, D.C.
20510

Dear Senator Kerry:

I have been asked to give written testimony in regards to Rural Health Care. My name is Sharon Witt and I am the Director of Nurses at Gordon Memorial Hospital in Gordon, Nebraska. This hospital is a 40 bed hospital and serves an area of at least a 50 mile radius. We are considered a bordertown as we are 19 miles from the South Dakota line and about 35 miles from a Public Health Service Hospital that services the Pine Ridge Indian Reservation. We receive high risk pregnancies and other referrals from this hospital.

There are a number of issues that concern me about rural health care especially in the panhandle of Nebraska. Although we are sparsely populated, we need to retain the services that our hospital and many like ours offer or health care for people in our area would be extremely difficult to access especially in emergency situations. Distances are real issues in this part of the country. We have the problem of being located far enough away from our state capitol, that many are discouraged trying to attend meetings to give a voice in the government and to address issues that are a concern to us. As you have probably heard many times, rural reimbursement is less than reimbursement in the cities for the same procedures and for as high of quality of care.

We have a real problem recruiting healthcare workers to our area because of our ruralness. Many people do not know what we mean when we say rural. We mean towns of 2,500 population or less, hospitals of 40 beds or so and many miles of distance in between towns.

For registered nurses, we would like to try solve some of our problem with recruitment by sending local people to school who would likely return to work in our hospital. However, even if we can manage funding, nursing education is not easily available. We need some A.D. programs in this end of the state and we need coordination for nursing education programs so that credits can be accepted from school to school. Nurses that graduate from A.D. programs need assurance that they can continue education to receive a B.S. degree.

Then of course there is the issue of tuition reimbursement. The people that I am speaking of are traditional students who find it necessary to keep their jobs to feed families. They cannot afford to leave the area financially or physically long enough to obtain education so we need to find ways to bring education to our area.

The medicare system has hassled health care so much with their criteria and paper work to the point that our system is taxed with having to hire more employees to accomplish what they require. This system forces us to spend more money, and for our efforts we receive less reimbursement. If clinically the patient cannot go home, we have to care for the patient with no compensation for the rest of their stay. If we calculate wrong and send the patient home too soon and they return and require hospitalization we are penalized. Did you know that there is no DRG for dying? If your only problem is that you are dying, you can go home to do that. If the family can't handle that we have several options, family pays if possible, and if not the hospital sends them out to suffer the best they can, or keeps them for no compensation. You say there are services like Home Health. Yes there is, but not for 24 hour a day care in our area. We have one Home Health nurse and a partime contract nurse for Home Health. This will not always meet the need, for these nurses have more than one patient to care for and many miles to travel.

My plea is that it is time the government remembered us and made a real effort to understand us before we are lost. Rural America is essential to the life blood of our country. I sincerely appreciate your interest, Senator Kerry, and many of us are hopeful that the voice of Rural America will be heard. Having been born and raised in this area, this is the land that I love and I wish for it to continue to be a place for future generations to live and prosper.

Sincerely yours,

Sharon Witt, RN

Sharon Witt, R.N.
Director of Nurses

STATEMENT OF JAMES F. PANZER, M.D.

I am a surgeon involved in rural health care. The future of rural health care is in some degree of jeopardy and there are several causes for this. First, medicine has become technologically complex. Due to necessity, rural health centers cannot provide all services. This is a natural event and will lead to significant consolidation of the delivery systems. This sharing should also apply to urban centers.

Another problem has been the degree of specialization and sub-specialization that has occurred in medicine. Family physicians of past eras were well-versed in the majority of health care services available at that time. Now however, with increased technology, knowledge and complexity of care, the rural family physician cannot singularly deliver this same standard of care given by an entire team of urban specialist. In addition, there has been a significant dilution of education in certain areas of expertise provided to the family practice resident. This is directly related to turf issues within the specialty fields and with the parent teaching institutions.

The University of Nebraska has attempted to address the problem of rural physicians by starting their dedicated course a year earlier in training. However even the University of Nebraska has multiple diverse missions and they are not totally compatible with each other. Probably the best long term measure of the effectiveness of a family physician training program is measured by the percentage of their graduates who enter the rural health care area. (Last year's class had only one graduates leaving the urban area.) Therefore their intent was appropriate and commendable but unsuccessful.

Other significant attempts to aid rural health care in our state is by out reach programs involving urban or semi-urban specialist who travel to smaller communities and provide clinical and sometimes minor operative care. This, by necessity, is limited by the required follow-up care needs.

A third and very significant problem for rural areas is the excessively high equipment costs in meeting the needs and demands of increased technology. This cost is actually higher for the rural areas than for their urban counterparts due to lack of ability to do mass purchasing, and the added transportation and shipping fees from the point of origin. Repair fees are more expensive as the technologist responsible for fixing the equipment must be paid travel time, lodging and mileage expense - and I assure you that the equipment company does not include this as a service benefit.

A young physician is taught medical care utilizing the newest available resources and they are not interested in entering practices where these resources and facilities are not available as they are at a greater risk. I recently lost my long-term surgical partner. The biggest impediment I have found to entice another surgeon to enter my busy surgical practice has been the attitudes of the wives. Most young women are not interested in living in rural areas. We have always thought that our quality of life was significantly better than the urban areas, however, recent reports call this into question.

I do not feel that a nurse practitioner or mid-wife placed in every small town is a viable solution, and neither would it be practical. Any and all medical personnel require significant assistance, both human resources and technology. To explain, a nurse practitioner cannot obtain a simple blood count easier than a specialty physician could. BOTH of them need additional technological resources. Neither is placing EMT personnel in rural areas a solution as EMTs also require physician participation in their training and aid. This brings up another pressing problem for rural areas - staffing small hospitals with R. N.'s, medical technologists and radiological technicians and other professional staff. Because of lack of availability many staff who are there are only available because their spouse lives in that specific area.

In summary, I feel that there will be ongoing consolidation, specialization, and a significant decrease in the availability of all health care services in small rural areas. As I stated earlier, this is a normal event, BUT why must the government significantly hasten this process? Current governmental reimbursements have a significant bias against rural areas and rural health care providers. This inequality occurs despite equal taxes levied on rural and urban areas. This discrimination is somewhat reversed from what I understand is practiced in Canadian outback areas where reimbursement is actually more than the urban. I commend the principle even recognizing that Canadian outback areas are much further out than they are in the United States.

Congress can best help rural areas by having equal reimbursement for equal treatment and reducing discrimination against rural health care. When DRGs initially were presented to us, the Blue Cross/Blue Shield intermediaries came to both Gordon and Chadron and I attended both meetings. They said that initially payments were going to be 25% based on DRG's and 75% on a cost basis. The second year was to be 50% - 50%, and the third 75% - 25% of the DRG to cost ratio. They then said that most hospitals would then go to 100% DRG's but rural areas would indefinitely remain 25% DRG and 75% costs. This has NOT been done and what we were told was not followed through. We probably could forgive this sin if there was not such a significant negative difference in DRG reimbursements. An example is a cardiac pacemaker - at one time our reimbursement was approximately $7,100 and our pacemaker. We now use a significantly cheaper pacemaker. I am shocked when I look at Denver's reimbursement for this same procedure. The majority of the cost is obviously in the cost of the pacemaker unit itself - simply practicing in Denver does not make the quality of the surgeon's work any better than a rural physician. This certainly is a slight and we should take great offense.

I am not totally opposed to National Health Care sponsored by the federal government. Philosophically I have always felt, that private care has always been a step above governmental, and that the private sector has always been more efficient than the public sector in terms of job performance. Due to significant gaps in coverage, National Health Care may eventually be the only solution. But it certainly will not solve your cost problems, which I know is Congress' #1 concern. Everybody would like to have health care costs less, but they also want the best.

Sincerely,

James F. Panzer, M.D., F.A.C.S.
Wallace/Panzer P.C.
807 N. Ash St.
Gordon, NE 69343

LETTER FROM CONNIE WELLMAN

Dear Senator Kerrey,

Today we live in one of the most powerful nations in the world. Yet one-third of all pregnant women do not see a doctor till it's time to have their baby.

The very poor get welfare, the old get Medicare, the people in the middle get nothing. People independently employed do not have the money for medical insurance because the cost is so high and they simply cannot afford it.

I would like to tell you a story as to why I feel the way I do.

I have two sisters whom I love very much. My youngest sister, age 25, married for 5 years, her and her husband own their own trucking company. They worked very hard to be a success. In September Pam became pregnant. They both were very happy and excited about the new baby. Pam was worried because they didn't have medical insurance. She decided to use my sister's doctor whom she liked very much.

After her first appointment in January she was told since she didn't have insurance at her next appointment she would have to pay the entire amount. In February she went to the doctor with one-half of the balance, $400, plus the $100 she paid on her first visit. The total bill was $940. They told Pam that she could not see the doctor until the total bill was paid.

I too became pregnant in January and decided to use the same doctor because both my sisters thought so highly of her. One difference between me and Pam was that I have insurance. I saw the doctor in March and told her I was very concerned about Pam because she had so much swelling and was going numb on one side and that they would not let Pam see her because of the money.

She told me that swelling was normal and numbness was from sleeping on one side to much and that she had no control over company policy.

She was the doctor, I took her word that she knew what was going on with Pam and conveyed the message to Pam. My other sister talked to the doctor in March also and was told the same thing. Not once did the doctor say, tell Pam to come in.

The first week in April Pam called the doctor four times telling them it was important that she talk to the doctor. She never got through. Pam passed away on April 8, 1990. She was carrying twins. Pam died of heart failure caused by toxemia. Toxemia is treatable if watched by a doctor. Pam was never taken care of because of money. How can doctors only care about money and not their patients? How can they put a price on human life, in our case three lives?

I know there are pros and cons to nationalized medicine, but at least everyone is cared for and maybe we would still have my sweet sister and her twin boys. Something has to be done so people don't die of neglect and causes that can be treated.

Yours truly,

Connie Wellman

LETTER FROM DIANE WHITE, COORDINATOR, SUNSHINE SENIOR CENTER

May 31, 1990

FROM: Diane White, Coord.
Sunshine Senior Center
140 W. Park
West Point, Ne. 68788

CONCERNING: Rural Health Care Issues

A shortage of doctors practicing in the rural areas is a major issue in the present and future of rural health care. What can be done to encourage doctors to practice in rural Ne.?

Increasing numbers of small, rural hospitals are closing. What steps can be taken to help these hospitals remain open?

Transportation to other areas for medical care becomes a serious problem for many elderly and low-income persons. To travel away from home for routine medical treatments, exams or hospitalization becomes an extra cost to already expensive health care.

Health insurance, for many, is not affordable. I, for one, would not have health coverage for myself and my family if my employer did not provide this as a fringe benefit. I could never afford the premiums.

I believe there will be an increasing need in the future for adult day care services and "in-home" services for the elderly. We'll need to make more of these services available and affordable.

Some programs already in existence, with which I personnally have had experience are free, or low-cost immunization clinics; commodities distribution for all ages and the elderly commodities program; WIC; Home Health care; care management services and nutrition sites for the elderly. I believe these programs to be very beneficial to overall health and that funding should continue or increase in these areas.

I do think that residents of eastern Ne. have greater access to adequate health care than less populated portions of the state.

Sincerely,

Diane White

PETITIONS FROM CONCERNED NEBRASKA CITIZENS

[CLERK'S NOTE.--The following petitions were submitted by concerned Nebraska citizens who were unable to attend the hearings and in lieu of a written statement.]

May 31, 1990

Senator J. Robert Kerrey
United States Senate
Washington, D.C. 20510

The rural physicians of Nebraska are extremely grateful for your concern related to rural health care issues. Your leadership in scheduling public hearings on rural health care in our state is commendable. The meetings in Fremont on Friday, June 1 at the Fremont Multi-purpose Senior Center from 3:00 p.m. - 4:30 p.m. and in Scottsbluff on Sunday June 3 at the Panhandle Station University of Nebraska 4502 Avenue I at 1:30 p.m. -3:00 p.m. have great potential for preserving rural health care in our state.

I am sorry that I cannot personally attend either of these public hearings. It is my understanding though that I may submit written testimony. In lieu of my personal testimony I would like to submit the following petition:

WHEREAS: Rural Nebraska in many places is desperate for physicians,

WHEREAS: The majority of rural physicians in Nebraska are in private practice,

WHEREAS: Congress mandated a Medicare Payment Floor in 1987 to protect underpaid physicians,

WHEREAS: The present Medicare payment floor set at 50% of the national average reimbursement rate frequently results in an annual payment penalty of nearly $50,000 for a physician to practice in rural Nebraska,

WHEREAS: The A.M.A. and the National Rural Health Advisory Committee support an 80% Medicare payment floor for rural physicians,

BE IT RESOLVED: That Congress should establish an 80% Medicare Prevailing Charge Floor for rural physicians in 1991.

Signed ______________________________

Furthermore, I encourage your support of the Rural Health Improvement Act sponsored by Senator Robert Packwood, Oregon. Bipartisan support is critical for this legislation to pass.

Sincerely,

[X] I am interested in attending a rural health caucus.

May 31, 1990

Senator J. Robert Kerrey
United States Senate
Washington, D.C. 20510

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WHEREAS: The A.M.A. and the National Rural Health Advisory Committee support an 80% Medicare payment floor for rural physicains,

BE IT RESOLVED: That Congress should establish an 80% Medicare Prevailing Charge Floor for rural physicians in 1991.

Signed, ______________________

Furthermore, I encourage your support of the Rural Health Improvement Act sponsored by Senator Robert Packwood, Oregon. Bipartisan support is critical for this legislation to pass.

Sincerely,

President

Senator J. Robert Kerrey
United States Senate
Washington, D.C. 20510

Dear Senator Kerrey:

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Signed, Gerald Kugler

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Sincerely, Gerald Kugler

[ ] I am interested in attending a rural health caucus.

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Signed. Joyce Lang

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Sincerely,

Joyce Lang

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Signed. Rodney Sang

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Signed. Velma J. Meyer

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Signed. Victor C Meyer

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Signed. Robert Worman

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Signed, Dwaine C. Hendrick

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Signed. Dana Meyer

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Signed. Mitzi K Meyer

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Signed. Shirley A Pledger

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Sincerely,

Shirley A Pledger

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Signed William D. [illegible] Mayor City of Franklin Nebr.

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William D. [illegible] Mayor City of Franklin Nebr.

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0190

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Signed, Neal Schwartz Mayor Village of Hildreth

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WHEREAS: The majority of rural physicians in Nebraska are in private practice.

WHEREAS: Congress mandated a Medicare Payment Floor in 1987 to protect underpaid physicians.

WHEREAS: The present Medicare payment floor set at 50% of the national average reimbursement rate frequently results in an annual payment penalty of nearly $50,000 for a physician to practice in rural Nebraska.

WHEREAS: The A.M.A. and the National Rural Health Advisory Committee support an 80% Medicare payment floor for rural physicains.

BE IT RESOLVED: That Congress should establish an 80% Medicare Prevailing Charge Floor for rural physicians in 1991.

Signed. Searl Schroder

Furthermore, I encourage your support of the Rural Health Improvement Act sponsored by Senator Robert Packwood, Oregon. Bipartisan support is critical for this legislation to pass.

Sincerely,

[ ] I am interested in attending a rural health caucus.

Senator J. Robert Kerrey
United States Senate
Washington, D.C. 20510

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Signed. Sarah [illegible]

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Signed. Alice Ann Swanson

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Signed. Wanda R. Johnson

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Signed. Barbara J. Carey

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Signed. Monica M. Anderson

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Sincerely,

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May 31, 1990

Honorable J. Robert Kerrey
United States Senate
Washington, DC 20510

Dear Senator Kerrey:

I regret that I am unable to personally attend either of your public hearings at Scottsbluff or Fremont because of my demanding medical schedule. It is my understanding that I may submit written testimony. In lieu of my personal testimony I submit the following petition:

WHEREAS: Rural Nebraska in many places is DESPERATE for physicians,

WHEREAS: The majority of rural physicians in Nebraska are in private practice,

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BE IT RESOLVED: That Congress should establish an 80% Medicare Prevailing Charge Floor for rural physicians in 1991.

Sincerely,

Hugh F. Leigh MD

Hugh F. Leigh, M. D.

P. S. I further encourage you to support the Rural Health Improvement Act sponsored by Senator Robert Packwood, Oregon. Bipartisan support is critical for this legislation to pass.

Thank you.

Senator J. Robert Kerrey
United States Senate
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Signed. albert a [illegible] MD

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albert a [illegible], MD

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Signed, [redacted] M.D.)

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Signed. B Douglas

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Sincerely, B Douglas

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Signed. Charlotte R. [illegible], MD

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Sincerely,
Charlotte R [illegible], MD

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Senator J. Robert Kerrey
United States Senate
Washington, D.C. 20510

Dear Senator Kerrey:

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BE IT RESOLVED: That Congress should establish an 80% Medicare Prevailing Charge Floor for rural physicians in 1991.

Signed.

Furthermore, I encourage your support of the Rural Health Improvement Act sponsored by Senator Robert Packwood, Oregon. Bipartisan support is critical for this legislation to pass.

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Signed. Wilma Schulz, RN

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Sincerely, Wilma Schulz, RN.

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Signed. H. A. Doering, M.D. 5/31/90

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Signed. Peggy S Fassler

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Sincerely,

Peggy S Fassler

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Signed. Nancy C Kotenek

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Signed. Ila Mae McConkey

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Signed Gerald Hartm

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Signed. Lori Bern

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WAHOO CLINIC, WAHOO, NEBR

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Signed. Priscilla Rudd MD

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Signed. JM French M.D
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